

FEDERAL INSURANCE COMPANY (the "Company")

BENEFICIARY DESIGNATION REQUEST

INSTRUCTIONS: Complete this form and retain a copy with your important papers.

Indicate: _____ Original Designation
 _____ Change of Beneficiary

Policyholder: _____

Policy Number: _____

Name of Insured Social Security Number

Address City State Zip Code

Hereby revoking any and all previous designations, I designate the person(s) on this form as my Beneficiary(ies) to receive any payment from the policy or certificate number shown above. I fully understand that this designation of Beneficiary(ies) only applies to the full Accidental Loss of Life Benefit Amount that is in force.

Date: _____ Insured's Signature: _____

_____%

Name of Beneficiary Relationship

Address City State Zip Code

_____%

Name of Beneficiary Relationship

Address City State Zip Code

_____%

Name of Beneficiary Relationship

Address City State Zip Code

_____%

Name of Beneficiary Relationship

Address City State Zip Code