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) 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

Original - Policyholder **Copy - Insured Person**