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

Original - Policyholder **Copy - Insured Person**