FEDERAL INSURANCE COMPANY (the "Company")

Indicate: _________ Original Designation
_________ Change of Beneficiary

Policyholder: ____ **Policy Number:** 6404-7229 ____________________

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 ______

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