

FEDERAL INSURANCE COMPANY (the "Company")

BENEFICIARY DESIGNATION REQUEST

GROUP TRAVEL ACCIDENT INSURANCE

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

Indicate: ☐ Original Designation
☐ Change of Beneficiary

Policyholder: American Lung Association

Policy Number: 6408-44-55

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