# 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: Town of Duxbury

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