CHUBB

Accidental Death & Dismemberment
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: **State of Florida**

Policy Number: **9906-63-97**

_____
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

Contingent Beneficiary:

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