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 Sherborn Policy Number: 9906-56-91

_____
Name of Insured Social Security Number

_____
Address City State Zip Code

Hereby revoking 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