FEDERAL INSURANCE COMPANY

IPEP Accidental Death and Dismemberment Coverage

BENEFICIARY DESIGNATION REQUEST

Indicate: _______ Original Designation
_______ Change of Beneficiary

Policyholder: Indiana Public Employees Plan INC **Policy Number:** 9908-72-13

Employer ____

____
Employee Name 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