

# CHUBB TRAVEL ACCIDENT INSURANCE BENEFICIARY DESIGNATION REQUEST

**FEDERAL INSURANCE COMPANY** (the "Company")

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

Indicate: \_\_\_\_\_ Original Designation  
                  \_\_\_\_\_ Change of Beneficiary

**Policyholder:** CHEIBA/Colorado School of Mines

**Policy Number:** 9906-91-71

\_\_\_\_\_  
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