FEDERAL INSURANCE COMPANY

IPEP Accidental Death and Dismemberment Coverage

BENEFICIARY DESIGNATION REQUEST

Indicate: _____ Original Designation
_____ Change of Beneficiary

Policyholder: Indiana Public Employees Plan Inc

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

toll free 800.382.8837 | phone 765.457.9161 | fax 765.868.3310

www.IPEP.com