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 ______

Original - Policyholder **Copy - Insured Person**