# *CHUBB TRAVEL ACCIDENT INSURANCE*

## BENEFICIARY DESIGNATION FORM

**Indicate:** _______ Original Designation
_______ Change of Beneficiary

**Policyholder:** ______________________________ **Policy Number:** ____________________

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**