VOLUNTEER FIREMAN'S INSURANCE SERVICES, INC.

BENEFICIARY DESIGNATION FOR ACCIDENT & SICKNESS POLICY

NAME OF ORGANIZATION: ____

MEMBER'S/EMPLOYEE'S NAME:____

MEMBER'S DATE OF BIRTH______________________________

DATE MEMBER JOINED ORGANIZATION:_____________________________

COMPLETE, SIGN AND DATE THIS BLOCK IF YOU WISH TO NAME OR CHANGE YOUR BENEFICIARY

PRIMARY
BENEFICIARY: NAME___________________________ RELATIONSHIP_________________________
DATE OF BIRTH_________________ SHARE___________%

NAME ___________________________ RELATIONSHIP ________________________
DATE OF BIRTH _________________ SHARE __________%

CONTINGENT
BENEFICIARY: NAME___________________________ RELATIONSHIP _________________________
DATE OF BIRTH ________________ SHARE __________%

NAME ___________________________ RELATIONSHIP _________________________
DATE OF BIRTH ________________ SHARE __________%

IF NONE OF THE ABOVE-NAMED BENEFICIARIES ARE LIVING AT THE TIME OF MY DEATH, I DIRECT THAT PAYMENT BE MADE TO MY ESTATE. I RESERVE THE RIGHT TO REVOKE OR CHANGE THIS DESIGNATION.

SIGNATURE____ DATE ____________________________

THIS FORM SHOULD BE RETAINED IN THE FILES OF YOUR DEPARTMENT OR ORGANIZATION.