

The Hirshorn Company

14 E. Highland Avenue, Philadelphia, PA 19118
800-242-8221 • www.hirshorn.com

Beneficiary Designation Request

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

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) 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**