

**Attachment
Beneficiary Designation**

Re: _____ Life Insurance Company
Contract # _____
Owner: _____

Primary Beneficiary: The State of Indiana for the amount of any medical assistance provided to _____ and _____.

c/o Office of Medicaid Policy and Planning 100%
402 W. Washington St. Room W382 Stop 07
Indianapolis, Indiana 46204-2776
Federal ID: 35-6000-158

Contingent Beneficiary: In equal shares to each child of mine who survives me and the descendants who survive me, collectively, by right of representation, of each child of mine who predeceases me. My children being:

_____, son/daughter ___%

Address: _____

DOB: _____

SSN: _____

_____, son/daughter ___%

Address: _____

DOB: _____

SSN: _____

_____, son/daughter ___%

Address: _____

DOB: _____

SSN: _____

Dated at _____, Indiana, this _____ day of _____, 2011.

X _____
Owner

Phone Number