Attachment
Beneficiary Designation

Re: ________________ Life Insurance Company
Contract #___________________
Owner: __________________________________

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

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