

Common Carrier Travel Accident Insurance Program

Virginia Surety Company, Inc.

Group Insurance Beneficiary Designation
(Original Designation)

Policy Number: VTA00015

Financial Institution: _____

What are the first 6 digits of your card? _____

(First 6 **only** for security reasons)

Cardholder Name: _____

Last Name

First Name

Middle Initial

Address: _____

Telephone: _____

I hereby designate as my beneficiary under the above identified policy (if more than one, indicate the % for each):

Beneficiary: _____

Last Name

First Name

Middle Initial

Address: _____

Relationship: _____

Date: _____ Signature: _____

If more space is needed, attach a separate piece of paper or continue on the back of this form.

Mail your completed form to:

Enhancement Services

P.O. Box 749

Mamaroneck, NY 10543