

Beneficiary Designation

Minnesota Life Insurance Company - A Securian Company
 400 Robert Street North • St. Paul, MN 55101-2098

MINNESOTA LIFE

GROUP NAME: Northern Arizona Public Employees Benefit Trust

POLICY NUMBER: 33585

Please check one of the following employers:

- City of Flagstaff
 Coconino County
 CCRASD
 Coconino Community College
 Flagstaff Housing Authority
 Flagstaff Unified School District
 NAIPTA

Insured's name (last, first, middle initial)		Social Security number	
Street address	City	State	Zip code

PRIMARY BENEFICIARY(IES). All of my death benefit shall be payable in equal shares (unless otherwise specified)* to the following persons. To receive the death benefit, a beneficiary must be living at the time of the insured's death. In the event a primary beneficiary is not living at the time of the insured's death, that beneficiary's portion shall be equally distributed to the remaining surviving primary beneficiaries. In the event of the simultaneous death of the insured and a beneficiary, the death benefit will be paid as if the insured survived the beneficiary.

PRIMARY BENEFICIARY NAME & ADDRESS	RELATIONSHIP TO THE INSURED	SHARE %* (must total 100%)

CONTINGENT BENEFICIARY. If none of the persons named as Primary Beneficiaries survives me, all of my death benefit shall be payable in equal shares (unless otherwise specified)* to the following persons. To receive the death benefit, a contingent beneficiary must be living at the time of the insured's death. In the event a contingent beneficiary is not living at the time of the insured's death, that beneficiary's portion shall be equally distributed to the remaining surviving beneficiaries. In the event of the simultaneous death of the insured and a beneficiary, the death benefit will be paid as if the insured survived the beneficiary.

CONTINGENT BENEFICIARY NAME & ADDRESS	RELATIONSHIP TO THE INSURED	SHARE %* (must total 100%)

Any previous designation of death beneficiary made by me is hereby revoked, and I reserve the power to change, modify or revoke this designation at any time by an instrument, similar in form to this one, delivered to and accepted by Minnesota Life. I understand my request to add or change a beneficiary will take effect as of the date it is signed but will not affect any payment made or action taken before receiving this request.

Insured's signature X	Date
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PLEASE SEND COMPLETED FORM TO YOUR LOCAL HUMAN RESOURCES DEPARTMENT