BENEFICIARY AFFIDAVIT
AND INDEMNIFICATION AGREEMENT

The purpose of this form is to designate a beneficiary who has an interest in property rights with respect to certain property, referred to herein as "Unearned Premium," which shall be distributed by UnitedHealthcare Insurance Company (the "Administrator") to the beneficiary upon execution of this form. This form shall be used for no other purpose.

I Affidavit

The undersigned, _____ (the "Beneficiary"), being duly sworn, under oath does depose and say:

1. That the Beneficiary is a surviving _____ (natural or legally adopted child, parent, sibling, other relative) of _____ (the "Decedent"), or a duly appointed fiduciary of the estate of the Decedent. (In the case of a duly appointed fiduciary of the estate of the Decedent, a copy of the Letters Testamentary, Probate Certificate, or similar document is required to be attached to this form.)

2. That the Beneficiary represents that he/she is the closest surviving relative or the Decedent, or the duly appointed fiduciary of the estate of the Decedent.

3. That the Beneficiary is over eighteen years of age, or is a guardian of a child of the Decedent who is under eighteen years of age, or is the duly appointed fiduciary of the estate of the Decedent.

4. That the Beneficiary has a legal claim to the Unearned Premium.

II Indemnification Agreement

The Beneficiary shall, in consideration for the receipt of the Unearned Premium, indemnify and reimburse the Administrator for all amounts required to be paid by the Administrator. The Beneficiary understands that this means that if, after

the Beneficiary receives the Unearned Premium, it is determined that the Administrator is required to pay all or part of the value of the Unearned Premium to someone else, or that the Administrator must pay cost and/or damages as a result of the distribution of the Unearned Premium to the Beneficiary, the Beneficiary will be responsible to reimburse the Administer for any such payments, costs and/or damages.

_____

Signature of Beneficiary

Dated this _____ day of _____, 20__.

Please print the required information:

Name of Beneficiary	Address	
City	State	Zip
Social Security No.	Date of Birth	Telephone No.

Please return completed form along with the original check to:

UnitedHealthcare
Railroad Accounts
185 Asylum St
CT039-03B
Hartford, CT 06103

STATE OF)
: ss.

COUNTY OF)

On this _____ day of _____, 20___, before me, a notary public, personally appeared _____ who acknowledged himself/herself to be the person whose name is signed to the foregoing instrument and that he/she executed the foregoing instrument for the purposes set forth therein.

IN WITNESS WHEREOF, I have hereunto set my hand and official seal.

[Notary Seal]

Notary Public
My Commission expires: