STATE FARM FUNDS
DESIGNATION OR CHANGE OF DEATH BENEFICIARY REQUEST
State Farm Funds Coverdell Education Savings Account

This form is used to designate or change the Death Beneficiary(ies) of your State Farm Funds Coverdell Education Savings Account and is to be completed by the Responsible Individual. I hereby revoke any prior death beneficiary designation and name the following as the Death Beneficiary(ies) of this Coverdell Education Savings Account, subject to my right to change this designation as the Responsible Individual as provided in the State Farm Funds Coverdell Education Savings Account Custodial Account Agreement. If you have any questions or need additional information before completing this form, please call **800-447-0740**.

Please print all information.

1 INSTRUCTIONS

1. This form is deemed valid by the Custodian if the following requirements have been met:
   a) The death beneficiary information is complete.
   b) It is signed and dated by the Responsible Individual.
   c) It is filed with the Custodian prior to the Designated Beneficiary's death.
2. To name more than four primary or secondary death beneficiaries:
   a) Attach a separate page and include, for each death beneficiary, all of the information required on the form.
   b) The additional page is signed and dated by the Responsible Individual.
3. See the State Farm Funds Coverdell Education Savings Account Custodial Account Agreement for additional provisions.

2 DESIGNATED BENEFICIARY INFORMATION

Individual under age 18 or special needs beneficiary for whom account is established

FIRST NAME | MIDDLE INITIAL | LAST NAME

ACCOUNT NUMBER | SOCIAL SECURITY NUMBER

3 RESPONSIBLE INDIVIDUAL INFORMATION

Individual named by the Depositor who is authorized to act on behalf of the designated beneficiary

FIRST NAME | MI | LAST NAME

ADDRESS

CITY/STATE/ZIP

TELEPHONE NUMBER | SOCIAL SECURITY NUMBER

4 DESIGNATION OF DEATH BENEFICIARY(IES)

PRIMARY BENEFICIARY(IES)

NAME | SOCIAL SECURITY NUMBER | RELATIONSHIP | DATE OF BIRTH (MM/DD/YYYY) | % OF ACCT.

STREET/CITY/STATE/ZIP

DEATH BENEFICIARY PARENT/LEGAL GUARDIAN NAME

NAME | SOCIAL SECURITY NUMBER | RELATIONSHIP | DATE OF BIRTH (MM/DD/YYYY) | % OF ACCT.

STREET/CITY/STATE/ZIP

DEATH BENEFICIARY PARENT/LEGAL GUARDIAN NAME

NAME | SOCIAL SECURITY NUMBER | RELATIONSHIP | DATE OF BIRTH (MM/DD/YYYY) | % OF ACCT.

STREET/CITY/STATE/ZIP

DEATH BENEFICIARY PARENT/LEGAL GUARDIAN NAME

NAME | SOCIAL SECURITY NUMBER | RELATIONSHIP | DATE OF BIRTH (MM/DD/YYYY) | % OF ACCT.

STREET/CITY/STATE/ZIP

DEATH BENEFICIARY PARENT/LEGAL GUARDIAN NAME

SECONDARY BENEFICIARY(IES)

NAME | SOCIAL SECURITY NUMBER | RELATIONSHIP | DATE OF BIRTH (MM/DD/YYYY) | % OF ACCT.

STREET/CITY/STATE/ZIP

DEATH BENEFICIARY PARENT/LEGAL GUARDIAN NAME

NAME | SOCIAL SECURITY NUMBER | RELATIONSHIP | DATE OF BIRTH (MM/DD/YYYY) | % OF ACCT.

STREET/CITY/STATE/ZIP

DEATH BENEFICIARY PARENT/LEGAL GUARDIAN NAME

NAME | SOCIAL SECURITY NUMBER | RELATIONSHIP | DATE OF BIRTH (MM/DD/YYYY) | % OF ACCT.

STREET/CITY/STATE/ZIP

DEATH BENEFICIARY PARENT/LEGAL GUARDIAN NAME

NAME | SOCIAL SECURITY NUMBER | RELATIONSHIP | DATE OF BIRTH (MM/DD/YYYY) | % OF ACCT.

STREET/CITY/STATE/ZIP

DEATH BENEFICIARY PARENT/LEGAL GUARDIAN NAME

5 SIGNATURE OF THE RESPONSIBLE INDIVIDUAL

RESPONSIBLE INDIVIDUAL'S SIGNATURE | DATE

Please fax or mail all signed completed forms to:

State Farm Funds
P.O. Box 4766
Chicago, IL 60680-4766
FAX: 312-557-3093