# ANNUITY PAYMENT PLAN ELECTION

North American Company
for Life and Health Insurance
Annuity Service Center
A Member of the Sammons Financial Group
PO Box 79905
Des Moines IA 50325-0905

___ - ___ - ____ Owner's Daytime Telephone Number

_____ Contract Number

## PAYMENT ELECTION

I, the contract owner, request, in lieu of all benefits otherwise payable to me, that the proceeds of the above annuity be paid in the manner indicated below.

**Please note that this is a final election that, once processed, cannot be changed or reversed.**

**Select one option.**

☐ **Option 1. Income for a specified period.**

Proceeds paid in equal installments for the duration of the specified period only. Upon the death of the primary payee, any remaining payments will be payable to the beneficiary.

The specified period shall be ☐☐ years.

☐ **Option 2. Life Only Income**

Proceeds paid during the lifetime of the primary payee. Upon the death of the primary payee, payments will cease.

**Please supply a copy of the payee's driver's license or birth certificate and complete the enclosed Life Only Disclaimer Statement (form 8968Z).**

☐ **Option 3. Life Income with installments for specified period certain.**

Proceeds paid during the lifetime of the primary payee. Upon the death of the primary payee, any remaining payments will be payable to the beneficiary.

The specified period certain shall be ☐☐ years.

**Please supply a copy of the payee's driver's license or birth certificate.**

☐ **Option 4. Income of a specified amount.**

Proceeds paid in equal installments to the primary payee until the proceeds, together with the interest thereon, are exhausted. Upon the death of the primary payee, any remaining payments will be payable to the beneficiary.

The specified amount shall be $☐☐☐☐☐ . ☐☐



$ 1 7 1 1 0 4

$1711040

PRT 02-07

☐ **Option 5.** **Joint and survivor income.**

Proceeds are paid during the lifetimes of both the primary and contingent payees. Upon the death of either payee, payments continue to the survivor of them for (Select one):

☐ 100% of original amount ☐ 67% of original amount ☐ 50% of original amount

**Please supply a copy of the payees' driver's licenses or birth certificates.**
**(Complete the enclosed Life Only Disclaimer Statement (form 8968Z) if not electing a specified period below.)**

Primary Payee First Name | Primary Payee Last Name

Contingent Payee First Name | Contingent Payee Last Name | Contingent Payee SSN

Date of Birth of Contingent Payee | Relationship to Payee

☐ With Specified Period of ☐☐ Years (If a specified period is not elected, payments will cease upon the death of the second payee.)

## PAYMENT DATE AND MODE

The first payment will be made within 31 days of our receipt of all documents needed to process your election, unless otherwise specified below, or unless the payment option elected requires an alternate first payment date:

I wish the payment date to be the ☐☐ day of the month.

Payment Mode (Select One): ☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually

**UNLESS LOST, THE POLICY CERTIFICATE MUST BE RETURNED BEFORE THIS PAYMENT PLAN ELECTION CAN BE PROCESSED. (Please select one)**

☐ Contract certificate enclosed.

☐ I have lost, destroyed, or mislaid my contract certificate specified above and request that the value of said contract be paid. I hereby agree (on my behalf and on behalf of my heirs, assigns, and legal representatives, or any other person claiming rights through me) to indemnify and protect the Company against any claim which may be asserted against the Company on the basis of such contract, and to reimburse the Company for any payment it may make, or expense it may incur, with respect to any such claim.

In agreeing to annuitize this contract, **North American Company for Life & Health Insurance** does not make any warranty as to penalty or the satisfaction of minimum distribution rules as set forth by the Internal Revenue Code. Subject to approval of this request by **North American Company for Life & Health Insurance Annuity Service Center, West Des Moines, Iowa**, I hereby revoke and cancel any prior request or election which I have made as owner.

$1711050



$ 1 7 1 1 0 5

**BENEFICIARY DESIGNATION*** (Beneficiary designation previously in effect will not be changed unless otherwise specified below) For option 1, 3, 4, or 5 (with period certain) the beneficiary shall be:

☐ Primary ☐ Contingent

First Name | MI | Last Name | Birth Date (mm/dd/yyyy)

Address | Social Security Number

City | State | Zip

Relationship | Percentage %

---

☐ Primary ☐ Contingent

First Name | MI | Last Name | Birth Date (mm/dd/yyyy)

Address | Social Security Number

City | State | Zip

Relationship | Percentage %

---

☐ Primary ☐ Contingent

☐ Trust** ☐ Corporation ☐ Estate ☐ Other

Name | Trust Date (mm/dd/yyyy)

Address | Tax ID Number

City | State | Zip

Percentage %

* If you are designating additional beneficiaries, please list them on a separate piece of paper that is signed and dated.
** Please complete and submit a copy of the Certification of Trust Agreement (form 10112Z) if designating a Trust as your beneficiary.



## ELECTION OF WITHHOLDING (must be completed)

You must indicate if Federal/State income taxes should be withheld from your payment by signing and dating this election form and returning it to **North American Company for Life & Health Insurance Annuity Service Center**. State taxes will be withheld only if required by your state. Even if you elect not to have Federal/State income taxes withheld, you are liable for Federal/State income taxes on the taxable portion of your benefits. You may also be subject to tax penalties under the Estimated Tax Payment rules if your payments of estimated tax and withholding, if any, are not adequate. **If no election is made, we are required to withhold Federal taxes and State taxes if applicable.**

Select One: ☐ I do not want Federal/State income tax withheld from my payment

☐ I do want Federal/State income tax withheld from my payment

Federal ☐☐☐ % State ☐☐☐ %

**OWNER'S TAXPAYER IDENTIFICATION NUMBER (TIN):**

☐☐☐ - ☐☐ - ☐☐☐☐ ☐☐ - ☐☐☐☐☐☐☐

Social Security Number Employer Identification Number

**JOINT OWNER'S TAXPAYER IDENTIFICATION NUMBER (TIN):**

☐☐☐ - ☐☐ - ☐☐☐☐ ☐☐ - ☐☐☐☐☐☐☐

Social Security Number Employer Identification Number

Certification - Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and;
2. I am not subject to back up withholding because (a) I am exempt from back up withholding, or (b) I have not been notified by the Internal Revenue Service that I am subject to back up withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to back up withholding, and;
3. I am a U.S. person (including a U.S. resident alien).

Dated at _____ City , _____ State

this _____ day of _____ , _____

☐☐☐☐☐☐☐☐☐☐☐☐ ☐☐☐☐☐☐☐☐☐☐☐☐ _____

Owner's First Name Owner's Last Name Owner's Signature

☐☐☐☐☐☐☐☐☐☐☐☐ ☐☐☐☐☐☐☐☐☐☐☐☐ _____

Joint Owner's First Name (if applicable) Joint Owner's Last Name (if applicable) Joint Owner's Signature (if applicable)

Please complete and submit a copy of the Certification of Trust Agreement, form 10112Z, if this policy is owned by a trust.

Signature of Irrevocable Beneficiary (if any) _____ Date _____

*Signature of Current Owner's Spouse _____ Date _____

**Signature of Disinterested Witness _____ Date _____

IMPORTANT NOTICES REGARDING SIGNATURE REQUIREMENTS

*If the current owner resides in one of the following community property states, the spouse's signature, if applicable, is required: AZ, CA, ID, LA, NM, NV, TX, AK, WA and WI.

**If the current owner resides in the state of MA, the signature of a disinterested witness is required. A disinterested person is described as anyone other than a designated beneficiary.