

# Request for Disbursement / Systematic Withdrawal For Non-Qualified Annuities Authorization

## INSURER

OM Financial Life Insurance Company

<b>Policy Number</b>	<b>Owner / Annuitant</b>	<b>Telephone Number</b>	
<b>Owner's Address--Street</b>	<b>City</b>	<b>State</b>	<b>Zip</b>

Check if new address

Payment requests will be mailed to the owner unless alternative instructions are shown below. If jointly owned, a check will be made payable to both owners but will be mailed to the first owner's address.

**Alternate Payee Name and Address**

Federal Express:     No     Yes: Account Number \_\_\_\_\_

**If you have questions regarding this form, please call the Service Center at (866) 599-2760.**

<b>What would you like to do?</b>	<input type="checkbox"/> <b>PARTIAL SURRENDER</b> <i>Complete sections 1, 5, 6 and 7</i>	<input type="checkbox"/> <b>FULL SURRENDER</b> <i>Complete sections 2, 4, 5, 6 and 7</i>	<input type="checkbox"/> <b>SYSTEMATIC WITHDRAWAL REQUEST</b> <i>Complete Sections 3, 5, 6 and 7</i>
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### SECTION 1 - When this section is complete, please proceed to Section 5.

**PARTIAL SURRENDER-** Do not return policy with this request form.

*Please select one box:*

- Partial surrender of \$\_\_\_\_\_ (Must be at least \$100)
- Maximum available "surrender charge free" partial surrender (if applicable)

*Please select one box:*

- I request the **gross** amount of the selection above. *(Amount paid will be decreased by any applicable deductions.)*
- I request the **net** amount of the selection above. *(Amount withdrawn will be increased by any applicable deductions.)*

This partial surrender is to be in accordance with and is subject to the provisions of the policy.

**Please proceed to Section 5.**

### SECTION 2 - When this is section complete, please proceed to Section 5.

#### **FULL SURRENDER**

**Please return policy with this request form. If policy is lost, please complete Section 4 of this form, then complete Section 5.**

- I hereby request the present cash surrender value of my policy listed above. I understand that surrender charges may be applicable.

Except for payment of the surrender value less any indebtedness to the Company under this policy, the Company is hereby released from all liability under this policy.

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## SECTION 3 - When this section is complete, please proceed to Section 5.

### SYSTEMATIC WITHDRAWAL REQUEST PAYMENT INFORMATION

Payment Amount – please select one box:

- INTEREST ONLY
- SPECIFIC DOLLAR AMOUNT – I hereby request payments of \$ \_\_\_\_\_  
If payment exceeds the free withdrawal amount specified in your policy, the withdrawal will be subject to applicable surrender charges.

Please select one box:

- I request the **gross** amount of the selection above. (Amount paid will be decreased by any applicable deductions)
- I request the **net** amount of the selection above. (Amount withdrawn will be increased by any applicable deductions)

Payment Frequency \*Not all policies are eligible for periodic payments.

Please select one box:  Monthly  Quarterly  Semiannual  Annual

Payment Start Date:  Immediately  Other: \_\_\_\_\_

Payment End Date (optional): \_\_\_\_\_

Note: If not specified, payments will continue until you notify us that you request payments to stop.

### Method of Distribution:

- Check
- Electronic Funds Transfer - If Electronic Funds Transfer is selected, indicate account information below:
- Checking account (Please include voided check with this form)
- Savings account (Please include deposit slip with this form)

Please proceed to Section 5.

## SECTION 4 - When this section is complete, please proceed to Section 5.

### LOST POLICY CERTIFICATION

- By checking this box, I hereby represent the above-referenced policy has been lost, mislaid, or destroyed and I am unable to locate it after careful search and inquiry. By my signature below, I agree to hold the Company harmless from all loss, expense and liability for which the Company may become liable as a direct or indirect result of accepting this transaction without requiring the return of the policy. If the policy or any interest thereon has at any time been assigned, transferred or pledged to any person, company or corporation, the undersigned hereby attaches a copy of the assignment or states that the date thereof is \_\_\_\_\_, that the assignment is (absolute or collateral) and that the full particulars are as follows:

Please proceed to Section 5.

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### SECTION 5 – NOTICE OF WITHHOLDING (MUST BE COMPLETED)

Federal Income Tax Withholding – We will withhold federal income taxes from your annuity distribution unless you elect not to have any withholding and provide your social security number or taxpayer identification number.

State Income Tax Withholding – State law regarding withholding state income taxes varies. Some states allow us to follow your federal income tax withholding instructions, but others require us to withhold. In states where withholding is voluntary we do not withhold state income taxes.

Any tax withholding election you make will remain in effect until you revoke it and you may revoke it at anytime.

If you elect not to have withholding apply to the distribution or do not have enough withheld you may be responsible for payment of estimated taxes. You may incur tax penalties if you elect not to have withholding apply and do not pay sufficient taxes. The Internal Revenue Service may impose tax penalties for distributions prior to age 59 ½. Please consult a tax advisor regarding your specific situation and then make your election.

FEDERAL	STATE
<input type="checkbox"/> <b>DO NOT</b> withhold Federal Income Tax <input type="checkbox"/> Withhold Federal Income Tax (The maximum amount may not exceed 50% of the taxable amount)	<input type="checkbox"/> <b>DO NOT</b> withhold State Income Tax <input type="checkbox"/> Withhold State income tax (Certain states allow you to specify the amount of state withholding. If applicable, please specify the amount of state withholding desired \$ _____ or % ____).

NOTE: IF YOU DO NOT MAKE AN ELECTION REGARDING WITHHOLDING AND THERE IS A TAXABLE EVENT, WITHHOLDING WILL OCCUR AS REQUIRED BY LAW.

**FOR CALIFORNIA RESIDENTS ONLY** - In addition to the above for partial withdrawals and/or surrenders, the undersigned expressly waives all protection under California Civil Code §1542. It is the undersigned's intention to fully, finally, and forever settle and release the Company for all matters relating to the transaction(s) herein described. In furtherance of this intention, the release herein given shall be and remain in effect as full and complete notwithstanding the discovery or existence of any additional or different claims or facts.

### SECTION 6 - CERTIFICATION (Must be Completed)

Under the penalties of perjury, I(we) certify that my Social Security/Taxpayer identification number on this form is correct, that I(we) am(are) a U.S. citizen. The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding. Additional IRS penalties that may be imposed by the Internal Revenue Service for failure to furnish the information.

(We) am(are) a non-resident alien, I(we) have provided (or am providing with this form) Form W-8BEN and included my U.S. taxpayer identification number in order to claim any applicable tax treaty benefits. I(We) are aware that there may be tax consequences associated with this transaction. I(We) are aware that OM Financial Life Insurance Company, affiliates and representatives cannot give tax advice and have been advised to consult an independent tax advisor

\_\_\_\_\_  
Owner (Taxpayer) (if corporately owned, include title)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Owner Social Security #/Taxpayer Identification #

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\_\_\_\_\_  
**Joint Owner** (Taxpayer) (if applicable)

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Joint Owner Social Security #/Taxpayer Identification #**

\_\_\_\_\_  
**Assignee** (if any)

\_\_\_\_\_  
**Other signatures** (partners, joint owners, etc.)

\_\_\_\_\_  
**Witness to all signatures**

\_\_\_\_\_  
**If corporately owned, signature and title of 2<sup>nd</sup> corporate officer**

\_\_\_\_\_  
**Irrevocable Beneficiary** (if any)

## SECTION 7 - COMMUNITY PROPERTY STATES

If you are a resident of the following States, please complete the additional information below:

**Arizona**  
**Louisiana**  
**Texas**

**California**  
**Nevada**  
**Washington**

**Idaho**  
**New Mexico**  
**Wisconsin**

1. If you have **never been married or were divorced or widowed prior to the issue date of this annuity**, please acknowledge by signing here:

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

2. If you are **currently married**, your spouse must consent to the transaction by signing below:

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

3. If your **spouse is deceased**, please attach a copy of the Death Certificate. **Date of Death:** \_\_\_\_\_

4. If you are **divorced after the issue date of this annuity**: **Date of Divorce:** \_\_\_\_\_

(A) And the policy was mentioned in the Divorce Decree or Property Settlement Agreement; please attach a certified copy of the document.

(B) and the policy was not mentioned directly or indirectly in the Decree or Property Settlement Agreement, it will be necessary for your ex-spouse to consent by signing here:

**Ex-spouse's Consent**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Unless the Company has been notified of a community property interest in this policy, the Company shall be entitled to rely on its good faith belief that no such interest exists and assumes no responsibility for inquiry. The insured and/or policy owner signing this form agree to indemnify and hold the Company harmless from the consequences of accepting this transaction.

**NO AGENT IS AUTHORIZED TO ALTER THE TERMS OF THE CONTRACT OR BIND THE COMPANY.**

**TO COMPLETE THIS FORM:**

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- 1) Print clearly using blue or black ink. Provide requested information in full. An incomplete form may delay processing.
- 2) If an Attorney-In Fact is signing this form, please include an original or certified copy of the Power-of-Attorney documentation accompanied by a notarized sample signature for the Attorney-In-Fact. This additional documentation may be excluded if previously submitted to OM Financial Life Insurance Company.

## WHERE TO SEND THIS FORM:

### Street Address:

OM Financial Life Insurance Company  
Service Center  
P.O. Box 725049  
Atlanta, GA 31139-2049

### Overnight Address:

OM Financial Life Insurance Company  
6425 Powers Ferry Road  
Suite 300  
Atlanta, GA 30339

### By fax:

(770) 690-1967

## FOR HELP OR QUESTIONS:

Contact your Registered Representative  
or  
OM Financial Life Insurance  
Company's Customer Service Center at (866) 599-2760