



SENTINEL SECURITY LIFE INSURANCE COMPANY
 P. O. Box 27248
 Salt Lake City, UT 84127

GUARANTEED INCOME ANNUITY CLAIM FORM

Deceased Information: (An Original Death Certificate is Required)

Name: _____ **Social Security Number:** _____
Date of Birth: _____ **Date of Death:** _____
Policy Number(s) of Deceased: _____

Beneficiary Information: (One form for each Beneficiary is Required)

Name: _____ **Social Security Number:** _____ **M** **F**
Address: _____
Street Address City State Zip Code
Date of Birth or Trust: _____ **Relationship to Deceased:** _____
Telephone Number: _____ **Email Address:** _____

SETTLEMENT OPTIONS

Note: Some options may not be available under this Contract, or if the Owner has elected a Settlement Option. Please refer to the actual Contract or contact Customer Service for clarification.

Option #1: Lump Sum Payment

For Contracts with the Legacy Benefit Rider or Accumulation Benefit Rider, the payment will equal the greater of Accumulation Value or 80% of the Legacy Benefit Base. The Accumulation Value is payable for Contracts with the Guaranteed Lifetime Withdrawal Benefit Rider.

Option #2: Spousal Continuation

Available only if the Claimant was the Deceased Owner's Spouse and was the sole designated Beneficiary. Ownership will transfer to the Claimant. Do not return the Contract. You must designate new beneficiaries if you elect this option.

Option #3: 5-Year Deferral

Defer Lump Sum Payment up to five years from date of death. You may request your claim payment at anytime within the deferral period by submitting a new claim form.

Option #4: Legacy Benefits

The Legacy Benefit Base will be paid in equal installment amounts over 5 years. This option must be selected within 60 days after we approve the death claim, and payments must begin no later than one year after the Owner's date of death. Not available with GLWB Rider.

Mode Monthly Quarterly Semiannually Annually

Option #5: Period Certain Only

Proceeds are paid as an income for a specific number of years in equal installments for a minimum of 5 years. A Supplementary Contract will be issued. Please refer to the Contract for the Basis of Computation.

Period Certain Years 5 10 15 20 Mode Monthly Quarterly Semiannually Annually

Option #6: Inherited IRA

Direct Transfer to an Inherited IRA Annuity with Sentinel Security Life

An agent who is appointed with Sentinel Security Life and licensed in your state must facilitate this request.

In addition to this form, the following are required:

- Annuity Application
- Inherited IRA Election Form

Direct Transfer to an Inherited IRA Annuity with Another Company

In addition to this form, completed IRA Transfer Paperwork with Letters of Acceptance are required. Additional requirements may exist at the receiving company.

Option #7: Life Income Only

Payments will be made for the lifetime of the payee. All payments of any kind will cease with the last payment due prior to the death of the Payee. The amount of each payment will be determined by Us at the time the option is elected.

Mode Monthly Quarterly Semiannually Annually

Option #8: Life Income with Guaranteed Period Certain

Payments will be made for a Period Certain and thereafter for the lifetime of the Payee. The amount of each payment will be determined by Us at the time the option is elected.

Period Certain Years 5 10 15 20 Mode Monthly Quarterly Semiannually Annually

NOTE: Per IRC Sec. 72(h), options 7 and 8 must be chosen within 60 days of the Annuitant's death or beneficiaries are subject to the same taxes as a lump sum payment election.



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TAX WITHHOLDING ELECTION: Form W-4P/OMB No. 1545-0074

Note: 10% Tax automatically withheld if withholding option not elected.

I am not under guardianship, nor have I made any assignment, pledge or executed any document affecting ownership or right to any monies due or to become due under this Contract, and further that no proceedings in bankruptcy are pending to which I am a party. I understand if there is a reportable distribution, it will be reported to the Internal Revenue Service (IRS). Unless waived by me or in the absence of an election by me, if there is a reportable distribution it will have income tax withheld at a flat 10% rate. **If you reside in CA, NC, OK, OR or GA, State Taxes will be withheld regardless of election due to State Regulations; if you reside in DE, IA, LA, MA, ME, NE, NC, OK, or VT, State Tax withholding is mandatory if Federal Income Tax is withheld.**

Please choose from the following:

I do NOT elect to have federal taxes withheld from my payments.

I do NOT elect to have state taxes withheld from my payments.

I elect to have federal income taxes withheld in the amount of \$ _____ or _____ %

I elect to have state income taxes withheld in the amount of \$ _____ or _____ %

FRAUD NOTICE

FOR RESIDENTS OF ALASKA, ARIZONA, ARKANSAS, CALIFORNIA, COLORADO, DELAWARE, DISTRICT OF COLUMBIA, HAWAII, IDAHO, INDIANA, KENTUCKY, LOUISIANA, MAINE, MASSACHUSETTS, MINNESOTA, NEW HAMPSHIRE, NEW MEXICO, OHIO, OKLAHOMA, PENNSYLVANIA, TENNESSEE, TEXAS, VIRGINIA – REQUIRED NOTICE: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

FLORIDA RESIDENTS – REQUIRED NOTICE: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

NEW JERSEY RESIDENTS – REQUIRED NOTICE: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NEW YORK RESIDENTS – REQUIRED NOTICE: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

BENEFICIARY'S CERTIFICATION

By signing this form I certify that after a careful and diligent search the Contract whose number is listed on this form has been either lost or destroyed and I agree to indemnify and hold Sentinel Security Life Insurance Company harmless and free from all claims, suits, or other actions that may arise if the original Contract is ever found; and to reimburse the Company for all costs and expenses of every kind and character, including but not limited to attorney fees, which the Company may be obligated to incur in the event the Contract is found and another claim is presented under it or by initialing here, I acknowledge that the Contract is enclosed. _____

All of the preceding answers and statements are true and complete and correctly recorded. The following statement is required by the IRS: UNDER PENALTY OF PERJURY, I CERTIFY THAT THE NUMBER SHOWN ON THIS FORM IS MY CORRECT TAXPAYER ID NUMBER, AND I AM NOT SUBJECT TO BACK-UP WITHHOLDING.

 Signature of Beneficiary

 Title (if Corporation, Estate, or Trust)

 Date



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BENEFICIARY DESIGNATION FORM: (Required for Options 2-5 and 8)

Name: _____ **Social Security Number:** _____
Policy Number(s): _____

This designation form revokes all previous Beneficiary designations. If a Primary Beneficiary or Contingent Beneficiary is to remain the same, such Beneficiary must be restated on this form. Changing beneficiaries may result in significant tax consequences, please consult your tax advisor prior to completing this form.

Name		Relationship to Owner	Primary	Contingent
Street Address		City		
State	Zip Code			
Social Security Number	Date of Birth	Phone Number	% Share	

Name		Relationship to Owner	Primary	Contingent
Street Address		City		
State	Zip Code			
Social Security Number	Date of Birth	Phone Number	% Share	

Name		Relationship to Owner	Primary	Contingent
Street Address		City		
State	Zip Code			
Social Security Number	Date of Birth	Phone Number	% Share	

Name		Relationship to Owner	Primary	Contingent
Street Address		City		
State	Zip Code			
Social Security Number	Date of Birth	Phone Number	% Share	

Name		Relationship to Owner	Primary	Contingent
Street Address		City		
State	Zip Code			
Social Security Number	Date of Birth	Phone Number	% Share	

Name		Relationship to Owner	Primary	Contingent
Street Address		City		
State	Zip Code			
Social Security Number	Date of Birth	Phone Number	% Share	

Name		Relationship to Owner	Primary	Contingent
Street Address		City		
State	Zip Code			
Social Security Number	Date of Birth	Phone Number	% Share	

Unless otherwise noted, if more than one Beneficiary is named, we will assume that all Beneficiaries are to share equally. If there are more than six (6) beneficiaries, please attach a second page. This change revokes all prior designations made by me and is subject to all the terms and provisions of the Contract. The change becomes effective on the Home Office date of recording, without prejudice to the Company of account of any payment made or any action taken or permitted by the Company before recording such change. If a trust is being named the Beneficiary, please include the name of the Trust, Trustee, Successor Trustee, and the Tax Identification Number of the Trust.

The following is required by the IRS: **UNDER PENALTY OF PERJURY, I CERTIFY THAT THE NUMBER SHOWN ON THIS FORM IS MY CORRECT SOCIAL SECURITY OR TAXPAYER ID NUMBER AND I AM NOT SUBJECT TO BACK-UP WITHHOLDING.**

 Signature of Beneficiary

 Date

FOR HOME OFFICE USE ONLY Recorded By: _____ Date: _____