SENTINEL SECURITY LIFE INSURANCE COMPANY
P. O. Box 27248
Salt lake City, UT 84127 - 0248

PERSONAL CHOICE PLUS 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 already elected a Settlement Option. Some contracts may have Surrender Charges or Market Value Adjustments which may impact the total Death Benefit payable. Please refer to the actual Contract or contact Customer Service for more information on your specific Contract.

☐ **Option #1: Lump Sum Payment**
The Death Benefits are paid in a lump sum. Surrender Chargers and / or Market Value Adjustment may impact the total benefit payable.

☐ **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: 10-Year Deferral**
Defer Death Proceeds Payment up to ten years from date of death. You may request your Death Proceeds payment at any time within the deferral period by submitting a Deferral Claim Payment Request. Surrender and Market Value Adjustments will apply for the remainder of the initial guarantee period. You must withdraw 100% of the Death Proceeds by the end of ten years from the date of death.

☐ **Option #4: Enhanced Death Benefits**
The Enhanced Benefit will be paid in equal installment amounts over 5 years. This option must be selected within 60 days after we approve the death claim. The Surrender Charges and Market Value Adjustments are waived with this option. Payments will begin one mode from the date of death.

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. The Inherited IRA guarantee period must be less than ten years. You must withdraw 100% of the Death Proceeds by the end of ten years from the date of death.In addition to this form, the following are required:

- Annuity Application
- Direct Custodial Transfer Request
- Inherited IRA Election Form
- Any required annuity new business forms

☐ **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**
Monthly payments will be made during 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.

☐ **Option #8: Life Income with Guaranteed Period Certain**
Monthly payments will be made for the Period Certain of 10 years 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.

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. The Surrender Charges and Market Value Adjustments are waived with these options.

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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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PERSONAL CHOICE PLUS ANNUITY CLAIM FORM

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

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