Physicians Mutual®
Insurance for all of us.™

Physicians Life Insurance Company
Annuity Customer Service
PO Box 2316
Omaha, NE 68172-4081
1.800.720.2891

Death Claim Statement for Annuity Contracts

The furnishing of this form or any forms supplemental thereto by the Company indicated above shall not constitute nor be considered an admission by the Company there is an annuity in force on the life of the person in question nor a waiver of any of its rights or defenses.

The Death Claim Statement must be made by the persons to whom the annuity is payable. If there is more than one Beneficiary, a separate form must be completed for each. The Beneficiary's signature is required in the presence of a witness.

Note: If the Beneficiary is not an individual, additional documentation as to who can sign on behalf of the designated Beneficiary may be required.

Owner Information

Owner's Name _____ Contract Number(s) _____

Date of Birth ____/____/____ (Month / Day / Year) Date of Death ____/____/____ (Month / Day / Year)

Cause of Death (Attach certified Death Certificate) _____

This contract under which claim is made must be received by the Company prior to settlement. If the contract cannot be returned with this statement, briefly explain reasons and give location of contract.

_____

Mode of Settlement Desired

- ☐ Spousal Continuance – Please continue this contract in my name. I am the spouse of the deceased and the Primary Beneficiary on the contract.
- ☐ Lump-sum cash distribution.
- ☐ Transfer my lump-sum cash distribution to _____. (Transfer paperwork is required.) Transfer will be processed and reported as a death payout to the Beneficiary.
- ☐ Periodic payment options may be available. Please call for quotes. (Additional forms will be required.)

Beneficiary Information

Beneficiary's Name _____

Address _____
Street

_____
City State Zip

Phone Number (____) _____ Date of Birth ____/____/____ (Month / Day / Year)

Social Security Number ___—___—____ OR Tax Identification Number ___—_____

Delivery Option

- ☐ Please mail my distribution using an overnight mail carrier. I understand the overnight delivery charge* will be deducted from my net annuity distribution.
  *Please contact our Annuity Customer Service Department for approximate delivery charges.
- ☐ Please mail my distribution 1st Class mail, United States Postal Service.

Note: If a delivery option is not selected, your distribution will be mailed via 1st Class mail, United States Postal Service.

Income Tax Withholding Notice and Election (Does not apply to Spousal Continuance Option or Periodic Payments)

The taxable portion of this distribution will be subject to 10% federal tax withholding unless you elect not to withhold. **If you do not check Box 1 under Election of Federal Tax Withholding, 10% federal income tax will be withheld from the taxable portion of your distribution.**

Your distribution may also be subject to state income tax withholding requirements. If you would like to have state income tax withheld, please indicate below. **Even if you do not elect state withholding, your state may require us to withhold state income tax from your distribution when federal income tax is withheld.** If your state does not have income tax, state withholding will not be withheld from your distribution.

If you elect not to withhold, or if you do not have enough federal or state income tax withheld from your distribution, you may be responsible for payment of estimated tax. You may incur penalties under the estimated tax rules if your withholding and estimated tax payments are not sufficient. Annuity Owners who receive a distribution prior to age 59½ may be subject to a 10% additional tax which is imposed by the Internal Revenue Service. Physicians Life Insurance Company does not provide tax advice. We recommend you contact your tax advisor for this distribution.

Election of Federal Tax Withholding (Please check only one box.)

1. ☐ I do not want federal income tax withheld from my distribution.
2. ☐ Please withhold federal income tax of $_____ **in addition** to the 10% required to be withheld from the taxable portion of my distribution.
3. ☐ Please withhold federal income tax of _____% **in addition** to the 10% required to be withheld from the taxable portion of my distribution.

Election of State Tax Withholding (Please check only one box.)

1. ☐ I do not want state income tax withheld from my distribution.
2. ☐ Please withhold state income tax of $_____ from the taxable portion of my distribution.
3. ☐ Please withhold state income tax of _____% from the taxable portion of my distribution.

New Beneficiary Information (Spousal Continuance Only)

All prior Beneficiary designations are hereby revoked and the following are designated as Beneficiaries under this contract. (Please attach an additional page if necessary.)

Primary Beneficiary

Name (Last, First, MI)	Address	Age	Relationship	Social Security Number/ Tax Identification Number	% Allocation

Contingent Beneficiary - If there is no Primary Beneficiary living to receive payment, proceeds will be paid to the Contingent Beneficiary.

Name (Last, First, MI)	Address	Age	Relationship	Social Security Number/ Tax Identification Number	% Allocation

Signatures and Acknowledgment

Any person, who knowingly and with intent to injure, defraud or deceive any insurance company or other persons, files a statement of claim containing any false, incomplete or misleading information commits a fraudulent insurance act subject to criminal prosecution and civil penalties and/or is guilty of a felony of the third degree.

AZ residents: For your protection, Arizona Law requires the following statement appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

I certify the information I have provided on this form is complete and accurate. I understand this request will not become effective until approved by the Company in accordance with the terms of the contract.

X _____ _____

Beneficiary's Signature Date

X _____ _____

Witness' Signature Date