



**SENTINEL SECURITY LIFE INSURANCE COMPANY**  
 P. O. Box 27248, Salt Lake City, UT 84127  
 1405 W 2200 S, Salt Lake City, UT 84119

# ANNUITY CLAIM FORM STATEMENT OF BENEFICIARY

**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. 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 clarification.

**OPTION #1: LUMP SUM PAYOUT**

This is only available if the Contract Owner has not already elected a Settlement Option. The Death Benefits are paid in a lump sum. Surrender Charges and / or Market Value Adjustments 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: 5-YEAR DEFERRAL**

Defer Lump Sum Payout up to 5th anniversary of date of death. Surrender Charges and Market Value Adjustments will apply for the remainder of the initial guarantee period. Do not return the Contract.

**OPTION #4: PAYMENTS FOR A PERIOD CERTAIN**

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 page 10 of the Contract for the Income for Specified Period Factors.

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

**OPTION #5: ANNUITY PAYMENT PLAN (Available only with Death Benefit Rider)**

NOTE: Per IRC Sec. 72(h), this option 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 this option.

**Life Annuity**

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.

**Mode**    **Monthly**    **Quarterly**    **Semiannually**    **Annually**

**Life Annuity with Period Certain**

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.

**Mode**    **Monthly**    **Quarterly**    **Semiannually**    **Annually**

**OPTION #6: INHERITED IRA (Available only to non-spouse beneficiaries)**

**Direct Transfer to a Stretch/Decedent 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 Custodial Transfer Request
- Any required annuity new business forms

**Direct Transfer to a Stretch/Decedent 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.



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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 \_\_\_\_\_ %

**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.

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



# ANNUITY CLAIM FORM STATEMENT OF BENEFICIARY

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

**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

**FOR HOME OFFICE USE ONLY** Recorded By: \_\_\_\_\_ Date: \_\_\_\_\_