

**WESTERN UNITED LIFE ASSURANCE COMPANY  
MANHATTAN LIFE INSURANCE COMPANY**

**Annuity Operations Office**

PO Box 2290 Spokane WA 99210-2217 • 929 W Sprague Ave Spokane WA 99201  
Tel 800.247.2045 • Fax 509.835.3190 • AnnuityServices@wula.com • ManhattanLife.com

**BENEFICIARY  
ANNUITY CLAIMANT  
STATEMENT**

**EACH CLAIMANT MUST COMPLETE A SEPARATE FORM**

**1. ANNUITY CONTRACT INFORMATION**

Name of Deceased ( <i>First, Middle, Last</i> )	Annuity Number(s)
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**2. THE CONTRACT (*Not applicable for a duplicate contract, use only if original contract cannot be found*)**

- Enclosed (*Specifically the original Page 3 of the contract*)
- Lost/Destroyed – I hereby declare under penalty of perjury that the above numbered contract has been lost or destroyed; that it has not been delivered to any person having any right, title or interest in it.

**3. CLAIMANT (*Beneficiary*)**

Name of Beneficiary	Beneficiary's SSN/TIN ( <i>if a trust or estate, provide the Federal Tax ID Number</i> )		
Address	City, State, Zip Code		
Birth/Trust Date ( <i>mm/dd/yyyy</i> )	Relation to Deceased	Telephone Number(s)	

**4. PAYMENT OPTION DESIRED**

*(not all Options may be available for this claim)*

- a.  Single Sum
- b.  Leave proceeds as "open claim" until further notice (*please complete and return this form*)
- c.  Settlement Option # \_\_\_\_\_ (*see Settlement Options in the contract*)
- i. Period: \_\_\_\_\_ First Payment will be distributed immediately upon annuitization
- ii. Mode:  Monthly  Quarterly  Semi-Annual  Annual
- iii. I understand that by selecting a settlement option, payments must continue as elected.
- d.  Direct Transfer / 1035 Exchange contract to \_\_\_\_\_

*(Name of Company)*

**For Options b and c in the event of my death pay proceeds to:**

Primary Beneficiary Name	Relationship to Me	Birth/Trust Date	SSN/Tax ID ( <i>optional</i> )
Address	City, State, Zip Code		
Primary Beneficiary Name	Relationship to Me	Birth/Trust Date	SSN/Tax ID ( <i>optional</i> )
Address	City, State, Zip Code		
Contingent Beneficiary Name	Relationship to Me	Birth/Trust Date	SSN/Tax ID ( <i>optional</i> )
Address	City, State, Zip Code		
Contingent Beneficiary Name	Relationship to Me	Birth/Trust Date	SSN/Tax ID ( <i>optional</i> )
Address	City, State, Zip Code		

If more space is needed, please attach a signed letter of instruction.

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**BENEFICIARY ANNUITY CLAIMANT'S STATEMENT**

**\*\*PLEASE ATTACH ORIGINAL CONTRACT(S) AND CERTIFIED DEATH CERTIFICATE(S)\*\*  
SEE INDIVIDUAL STATE FRAUD NOTICES ON THE FINAL PAGE**

**5. PRIVACY STATEMENT**

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I understand that the Company may collect personal information about me and others I have identified in this Annuity Claimant's Statement. I further understand that the following Privacy Notice is given on behalf of the Company and it describes the general policy of the Company regarding the personal information of customers.

Personal Information Collected All of the information the Company collects is referred to in this Privacy Statement as "Information" and includes:

- Information from me, such as name, address, social security number, salary, assets, liabilities, and beneficiaries,
- Information that the Company obtains through its insurance producers and brokers, and
- Information regarding my business with the Company

Information Security The Company restricts access to Information in its possession to individuals who need it to work on my account. The Company maintains physical, electronic, and procedural safeguards that comply with federal regulation to guard my information.

Information the Company Shares Except as allowed or required by law, the Company does not disclose information about customers or former customers to third parties.

Manhattan Life Group  
Attention Customer Privacy Inquiries  
10777 Northwest Freeway, Houston TX 77092

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**6. AUTHORIZATION FOR DIRECT DEPOSIT**

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If a voided check is attached, I hereby authorize the Company to initiate credit entries to my checking account. The Financial Institution named below is hereby authorized to credit the same to my checking account as indicated. **These credits will be authorized for all annuity contracts that I am a beneficiary to, unless I notify you otherwise in writing.**

**Financial Institution Name:** \_\_\_\_\_

**ATTACH A VOIDED CHECK**

This transaction will not be processed without a voided check.

This agreement will remain in effect until the Company terminates it or until a written termination notice is received from me, and the Company has sufficient time to act upon it. If, at any time my Financial Institution changes, I will provide a new Authorization for Direct Deposit form and funds will be re-directed to my address of record until the new authorization is provided.

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**BENEFICIARY ANNUITY CLAIMANT'S STATEMENT**

**7. ELECTION FOR WITHHOLDING**

*Substitute IRS Form W-4P OMB No.1545-0074*

Federal and some State laws make payments subject to withholding. The law requires that you be told three things:

- a. You do not have to have any money withheld from your periodic payments.
- b. After you have made a choice, you can change it at any time by writing to us. Please allow 30 days for the change.
- c. Even if you elect not to have income tax withheld, you are liable for payment of income tax on the taxable portion of your distribution. You also may be subject to tax penalties under the estimated tax payment rules if your payments of estimated tax and withholding, if any, are not adequate.

**CHECK FEDERAL AND/OR STATE (if applicable)**

**If Not Checked and the Payment Amount is Sufficient, We are Required to Withhold Income Tax. We are Required to Withhold if Your Resident Address is Outside of the United States.**

**FEDERAL:**

- DO NOT WITHHOLD**  
federal income tax from my distribution
- WITHHOLD**
  - 10% of taxable portion
  - 20% of taxable portion (20% is generally required on all qualified funds except IRA's)
  - Other (specify) \_\_\_\_\_

**STATE:** \_\_\_\_\_

- DO NOT WITHHOLD**  
state income tax from my distribution
  - WITHHOLD**
    - % of taxable portion (specify) \_\_\_\_\_
    - \$ of taxable portion (specify) \_\_\_\_\_
- (SEE STATE WITHHOLDING INSTRUCTIONS)**

**8. TAXPAYER IDENTIFICATION NUMBER AND CERTIFICATION**

*Substitute IRS Form W-9*

I understand that failure to furnish my correct TIN (taxpayer identification number), may result in a \$50 penalty for each failure, imposed by the Internal Revenue Service (IRS). I also understand the Company would be required to withhold an additional amount according to IRS guidelines. IRS Instructions are available upon request.

Under penalties of perjury, I certify that:

- a. The number shown on this form is my correct taxpayer identification number; and
- b. I am not subject to backup withholding due to failure to report interest and dividend income; and  
 I have checked this box because I am subject to backup withholding. **(Check ONLY if applicable)**
- c. I am a U.S. citizen or other U.S. person.

**9. REQUIRED SIGNATURES**

I certify, under penalties of perjury, that all information reported herein is correct.

I understand and agree that the furnishing of this form or the furnishing of any form supplemental thereto, does not constitute and will not be considered as a waiver of any of the Company's rights with respect to liability under the contract, or the identity of persons entitled to benefits payable thereunder or of any other rights or defenses available to the Company.

**Notice to Residents of New York:** 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 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.

**The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.**

Beneficiary Signature <i>(Title if applicable)</i>	Beneficiary Printed Name	Date
Witness Signature	Witness Printed Name	Date

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## BENEFICIARY ANNUITY CLAIMANT'S STATEMENT

- AK** A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.
- AR, LA, RI, TX and WV** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
- AZ** For your protection Arizona law requires the following statement to 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.
- CA** For your protection California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.
- CO** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.
- AL, DC** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
- DE, ID, IN and OK** **WARNING:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.
- FL** Any person who knowingly and with the 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.
- KY** Any person who knowingly and with intent to defraud any insurance company or other person files a 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.
- MD** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
- ME, TN, VA and WA** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.
- MN** A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.
- NH** Any person who, with the purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in **N.H. Rev. Stat. Ann. § 638:20.**
- NJ** Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.
- NM** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.
- OH** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.
- OR** Any person who knowingly and with INTENT TO DEFRAUD or solicit another to defraud an insurer: (1) by submitting an application, or (2) by filing a claim containing a false statement as to any MATERIAL FACT, MAY BE violating state law.
- PA** 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.
- PR** Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than \$5,000 and not more than \$10,000, or a fixed term of imprisonment for 3 years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of 5 years, if extenuating circumstances are present, it may be reduced to a minimum of 2 years.

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