



**Member Life Insurance and Annuities Companies:**  
 Annuity Investors Life Insurance Company®  
 Great American Life Insurance Company®  
 Manhattan National Life Insurance Company

**Administration for Life Insurance and Annuities:**  
 Central Reserve Life Insurance Company  
 Loyal American Life Insurance Company®  
 Provident American Life & Health Insurance Company  
 Continental General Insurance Company®

**Mailing Address:** P.O. Box 5420, Cincinnati, OH 45201-5420  
**Overnight Address:** 301 E Fourth Street, 10N, Cincinnati, OH 45202  
 (800) 854-3649

## Annuity Claim Form

*Use this form to file a claim on an annuity contract that is still in deferred status.*

**Step 1 – Complete all boxes in the table below. Please note, if there are multiple beneficiaries, we will normally require completed claim forms from all beneficiaries before we process your claim. If the Claimant is an entity (such as a trust, estate or corporation), use the name of the entity in the Name field below.**

Information about the DECEASED		Information about the CLAIMANT	
Name		Name	
Policy #(s)		Relationship to Deceased	Social Security Number/EIN
Social Security Number		Date of Birth <i>(Not needed for Trust/Estate)</i>	Daytime Phone Number
Date of Death		Address	
State of Permanent Residence on Date of Death		City, State, ZIP & Country	

Would you like to receive email notifications on the status of this request? ☐ Yes ☐ No Email Address: \_\_\_\_\_

NOTE: This will only apply to this request. Email notifications will be sent from 'no-reply@gaig.com' or 'noreplyclaims@gaig.com.' Please be sure to remove these addresses from your list of blocked senders.

Is the claimant a U.S. citizen or other U.S. person? ☐ Yes ☐ No

A U.S. person includes a noncitizen who has a green card or who is present in the U.S. (with or without documentation) for a substantial period of time. See IRS Publication 519. A U.S. person also includes a U.S. estate or trust, or a business organized in the U.S. If the claimant is not a U.S. citizen or other U.S. person, an IRS Form W-8BEN or W-8BEN-E will be required.

**Step 2 – Select ONE of the following options AND complete that part of the form. Your selection is final and cannot be changed or revoked.**

☐ **SUCCESSOR OWNER**

By choosing this option, you will take over ownership of the annuity contract. You will continue to be subject to all terms and conditions of the contract, including any contract charges that may still apply. If you are age 95 or older, a lump sum payment or annuitization (stream of payments) will be required unless income rider benefits have started or will start now. This option may be elected only if the sole beneficiary of the contract is the surviving spouse, civil union partner, or domestic partner of the deceased.

☐ **LUMP SUM PAYMENT**

By choosing this option, you will receive payment of your entire interest in the annuity contract in one lump sum (payment to beneficiary/Rollover/Transfer/1035/Exchange).

☐ **STREAM OF PAYMENTS**

By choosing this option, you will receive a stream of periodic payments.

**Fraud Warning for 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.

**Fraud Warnings and Interest Information for Other States:** *please see the last 3 pages of this packet.*

**SUCCESSOR OWNER** Complete this page if you are a surviving spouse and want to take over ownership of the annuity contract.

- 1. Beneficiary Designation for Successor Owner** - As the new owner, you will need to name new beneficiaries to receive any death benefit payable upon your death. You should not name yourself. All prior beneficiary designations are revoked. Unless otherwise indicated, benefits will be paid to a Contingent beneficiary only if no Primary beneficiary is surviving, and if more than one beneficiary has equal priority, benefits will be paid in equal shares or all to the survivor. If percentages are specified, they must total 100% for Primary, and 100% for Contingent (if any).
- For each beneficiary, please show full name, address, relationship to you, date of birth, and Social Security number.
  - If a trust is named as a beneficiary, please provide the trust's name and the trust agreement date in the "Name" space below.
  - If you do not specify whether a beneficiary is Primary or Contingent, we will treat the beneficiary as a Primary beneficiary.

New Beneficiary Designation of Successor Owner			
<input type="checkbox"/> Primary	<input type="checkbox"/> Contingent	Percentage _____%	
Name _____		Name _____	
Address _____		Address _____	
City _____ State _____ ZIP _____		City _____ State _____ ZIP _____	
SSN/EIN _____ Relationship _____		SSN/EIN _____ Relationship _____	
Phone # (_____) _____ Date of Birth _____		Phone # (_____) _____ Date of Birth _____	
<input type="checkbox"/> Primary	<input type="checkbox"/> Contingent	Percentage _____%	
Name _____		Name _____	
Address _____		Address _____	
City _____ State _____ ZIP _____		City _____ State _____ ZIP _____	
SSN/EIN _____ Relationship _____		SSN/EIN _____ Relationship _____	
Phone # (_____) _____ Date of Birth _____		Phone # (_____) _____ Date of Birth _____	

*If you need additional space to name beneficiaries, please attach a page containing the policy number that is **signed and dated** by you.*

**2. Rider Continuation**

The guaranteed withdrawal or death benefit rider in effect at the time of death will continue when permitted by its terms unless you make written request to terminate it. A charge applies for any period that the rider remains in effect.

- ☐ Check here **only if you wish to terminate** the rider. If you check this box, all benefits under the rider will cease. If terminated, a rider may not be reactivated.

- 3. Agreement and Certification for Successor Owner Election** - As claimant, I irrevocably elect to become successor owner of the annuity contract. I agree to be bound by all of the terms and conditions of the annuity contract, **including those related to any contract charges that may still apply**. Under penalties of perjury, I certify that the number shown on this form is my correct taxpayer identification number.

\_\_\_\_\_  
Claimant / Successor Owner Signature

\_\_\_\_\_  
Date

- 4. Plan Administrator Certification and Authorization.** Plan Administrator to complete this section. This authorization is required if this contract is a tax-sheltered 403(b), 401(k) or 457 plan.

Name of Employer Plan _____	Name of Plan Administrator _____
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The Plan Administrator certifies that the **successor owner election** requested by the claimant is permitted under the employer's plan. The Plan Administrator authorizes the request to be processed as indicated above.

\_\_\_\_\_  
Plan Administrator Signature

\_\_\_\_\_  
Date



The remaining pages are not needed if you have selected Successor Owner.

**LUMP SUM PAYMENT**

Complete this section if you want your portion of the death benefit in one payment.

**1. Form of Payment – Check one box.**

- ☐ Payment to me. Unless otherwise indicated, payment will be sent by regular mail.
- ☐ Direct rollover, direct transfer, or 1035 exchange to another annuity or tax qualified account.  
We must receive a letter of acceptance from the new company.

New Company's Name
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**IMPORTANT NOTE FOR TRANSFERS AND ROLLOVERS OF TAX-QUALIFIED FUNDS.** Please check one of the boxes below regarding any required minimum distributions (RMDs) for the current or prior tax year(s). If neither box is checked, we will not send you an RMD before sending your proceeds to the new company unless mandated by IRS regulations.

- ☐ **DO NOT send me any RMD payment** before the transfer or rollover. If this is an IRA-to-IRA direct transfer, I agree that I am responsible for paying any applicable RMDs. If this is a rollover from a 403(b) plan, I certify that the decedent satisfied all RMDs for this contract for the year of death and all prior years from another permitted source and I understand that if any RMDs from a prior year are left unpaid, that amount is not eligible for rollover and tax penalties may apply.

- ☐ **DO send me any RMD payment**

- ☐ (Optional) I would like to receive my check via Express delivery. Express deliveries cannot be sent to a PO Box address. A \$20 fee will be deducted from the death benefit proceeds. Electing express delivery will not expedite processing time.

**2. Income Tax Withholding**

If this contract is an IRA or a Non-Qualified annuity, tax withholding is not mandatory. If a withholding election is not indicated OR if you choose to have taxes withheld and a preference is not indicated, 10% will be withheld for federal income tax unless the distribution is a direct rollover, direct transfer or 1035 exchange.

If this contract is a tax-sheltered 403(b), 401(k) or 457 plan, a minimum of 20% federal income tax withholding is required by the IRS unless your distribution is a direct rollover or required minimum distribution (RMD).

**If no selection is made, we will withhold the default or mandatory amount required. If federal income tax withholding is elected, state income tax withholding may also apply due to state requirements.**

**For an RMD, if a withholding election is not indicated OR if you choose to have taxes withheld and a preference is not indicated, 10% will be withheld for federal income tax.**

- ☐ Withhold the default or mandatory amount required for federal and state income tax.
- ☐ To withhold more than the default or mandatory federal or state amounts required, please specify **total** percentage: \_\_\_\_\_% for federal income tax \_\_\_\_\_% for state income tax
- ☐ DO NOT withhold federal income tax or state income tax unless required.

Whether or not taxes are withheld, you will be liable for payment of all applicable federal and state income taxes on the taxable portion of the payment. You may also be subject to penalties under the estimated tax rules if your withholding and estimated tax payments, if any, are not adequate.

**3. Special Tax Notice Regarding Plan Payments**

This section is required only if this contract is a tax-sheltered 403(b), 401(k) or 457 plan.

The enclosed Special Tax Notice contains information about rollover rights and death benefit treatment, and is being provided for your information. Please contact our office prior to submitting this form if you did not receive the Special Tax Notice. Unless you check the box below, we will hold your request for 30 days while you consider your options.

- ☐ I received the Special Tax Notice. I waive my 30-day consideration period.

➔ **Continue to next page to complete Lump Sum Payment.**

**4. Agreement and Certification**

I request the death benefit to be paid in a lump sum as indicated above. I agree to hold the company harmless against all claims made by reason of this payment. If the contract is not returned with this form, I hereby certify that the contract is not in my possession and has not been assigned, transferred, or pledged; and I also agree that the contract is no longer in effect and I will return it if found.

Under penalties of perjury, I certify that (1) the number shown on this form is my correct taxpayer identification number, and (2) I am not subject to backup withholding as a result of a failure to report all interest or dividends, or the Internal Revenue Service has notified me that I am no longer subject to backup withholding.

\_\_\_\_\_  
Signature of Claimant\_\_\_\_\_  
Title (Trustee/Executor/Other Title/Beneficiary)\_\_\_\_\_  
Date**5. Plan Administrator Certification and Authorization**

Plan Administrator to complete this section. This authorization is required if this this contract is a tax-sheltered 403(b), 401(k) or 457 plan.

Name of Employer Plan	Name of Plan Administrator
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The Plan Administrator certifies that the claimant is entitled to benefits under the employer's plan and that the **lump sum payment** requested by the claimant is permitted under the employer's plan. The Plan Administrator authorizes the request to be processed as indicated above.

\_\_\_\_\_  
Plan Administrator Signature\_\_\_\_\_  
Date

The remaining pages are not needed if you have selected a Lump Sum Payment.

## STREAM OF PAYMENTS

Complete this section if you want to receive a stream of payments.

### 1. Payment Options

Please select one of the following.

*Note:* All options may not be available for a particular contract. The amount of payment under an option will depend on the amount applied to that option, the length of time or life over which payments will be made, and the payment frequency. Please contact us if you want an estimate of the payment amount. Once we process your claim, you may not modify scheduled payments or take the commuted value unless except as may be permitted by the terms of the annuity contract.

- ☐ **Payments for a specified period.** Payments will continue for the specified period, whether or not you are alive. If you die before the end of the specified period, the remaining payments will be made to your contingent payee(s).

**Check one box below** to specify the period over which payments are to be made.

Payments for a period of ☐ 3 years ☐ 5 years ☐ 7 years ☐ 10 years ☐ \_\_\_\_ years

The specified period **cannot** exceed your life expectancy or any shorter period required by federal tax law.

- ☐ **Payments for Life.** Payments will continue as long as you live, but will stop upon your death. This option is not available to certain claimants because of federal tax law restrictions.

Proof of your age required in the form of a copy of a birth certificate, driver's license, or passport, together with proof of any name change.

- ☐ **Payments for Life With a Minimum Specified Period.** Payments will continue as long as you live. If you outlive the minimum specified period, payments stop on your death. If you die before the end of the minimum specified period, payments will continue to your contingent payees for the balance of the minimum specified period and then stop. This option is not available to certain claimants because of federal tax law restrictions.

Proof of your age required in the form of a copy of a birth certificate, driver's license, or passport, together with proof of any name change.

**Check the box below** to indicate the minimum fixed period over which payments are to be made.

Payments for a minimum specified period of ☐ 3 years ☐ 5 years ☐ 7 years ☐ 10 years ☐ \_\_\_\_ years

The specified period **cannot** exceed your life expectancy or any shorter period required by federal tax law.

- ☐ **Other form** provided by the contract or as mutually agreed upon. Specify requested option below.

### 2. Payment Frequency

*Note:* Most contracts provide for payments to be made at the end of each payment period. For example, if you request annual payments, your first payment will be made **one year after** the effective date of your election. Payment amounts must meet contract minimums.

Payments to be made ☐ Monthly ☐ Quarterly ☐ Semi-annually ☐ Annually

➔ *Continue to next page to complete Stream of Payments.*

### 3. Contingent Payee Designation

If you have selected **Payments for a Specified Period** or **Payments for Life with Minimum Specified Period**, payments may extend beyond your life. The beneficiary section of the contract no longer applies. You may tell us who to pay if payments remain after your death.

If you name more than one contingent payee, benefits will be paid in equal shares or all to the survivor unless you specify otherwise. If percentages are specified, they must total 100%.

- For each contingent payee, please show full name, address, relationship, date of birth, phone number and Social Security number.
- If a trust is named as a contingent payee, please provide the trust's name and the trust agreement date in the "Name" space.

New Contingent Payee Designation	
Percentage _____% Name _____ Address _____ City _____ State _____ ZIP _____ SSN/EIN _____ Relationship _____ Phone # (_____) _____ Date of Birth _____	Percentage _____% Name _____ Address _____ City _____ State _____ ZIP _____ SSN/EIN _____ Relationship _____ Phone # (_____) _____ Date of Birth _____
Percentage _____% Name _____ Address _____ City _____ State _____ ZIP _____ SSN/EIN _____ Relationship _____ Phone # (_____) _____ Date of Birth _____	Percentage _____% Name _____ Address _____ City _____ State _____ ZIP _____ SSN/EIN _____ Relationship _____ Phone # (_____) _____ Date of Birth _____

*If you need additional space to name payees, please attach a page containing the policy number your signature and date.*

### 4. Payment Method

- ☐ **By Check.** We will make payments by check to you, as the claimant, at the address you provided on page 1.
- ☐ **By Automatic/Direct Deposit.** We will make payments by depositing annuity benefit payments into the account identified below. *Note:* We will make payments by check until automatic/direct deposit arrangements have been completed. I hereby authorize the deposit of my annuity payments into my account identified below, and the adjustment of my account for any overpayments.

Financial Institution Name <i>Note: Attach a voided check or a deposit slip.</i>		
Type of Account <input type="checkbox"/> Checking <input type="checkbox"/> Savings	Account Number	Routing Number

➔ **Continue to next page to complete Stream of Payments.**

**5. Income Tax Withholding**

Please make your federal income tax withholding election:

- ☐ Do **NOT** withhold federal income tax unless required.
- ☐ Withhold federal income tax by the percentage indicated here: \_\_\_\_\_%

If the section above is not complete, we will withhold taxes based on tables for a married taxpayer with three exemptions. State income tax withholding may also apply. Whether or not taxes are withheld, you will be liable for payment of all applicable federal and state income taxes on the taxable portion of the payment. You may also be subject to penalties under the estimated tax rules if your withholding and estimated tax payments, if any, are not adequate. Any withholding election will remain in effect until revoked. You may revoke any withholding election for annuity payments not yet distributed by notifying us in writing at any time.

**6. Required Minimum Distribution (RMD) Information**

If an RMD is due for the current or any prior year and the stream of payments will not be sufficient to meet it, we will send you a lump sum payment of the amount needed unless you check the box below. Unless you tell us otherwise, the withholding you selected in section 5 will apply to this payment. If you did not make an election, we will withhold 10% for federal income tax.

- ☐ I certify that the decedent has taken all RMDs for *this* contract for the year of death and all prior years in whole or in part from another permitted source.

**7. Special Tax Notice Regarding Plan Payments**

This section is required only if this contract is a tax-sheltered 403(b), 401(k) or 457 plan.

The enclosed Special Tax Notice contains information about rollover rights and death benefit treatment, and is being provided for your information. Please contact our office prior to submitting this form if you did not receive the Special Tax Notice. Unless you check the box below, we will hold your request for 30 days while you consider your options.

- ☐ I received the Special Tax Notice. I waive my 30-day consideration period.

**8. Agreement and Certification**

I request the death benefit to be paid as a stream of payments as indicated above. I agree to the company harmless against all claims made by reason of these payments. If the contract is not returned with this form, I hereby certify that the contract is not in my possession and has not been assigned, transferred, or pledged; and I also agree that the contract is no longer in effect and I will return it if found.

Under penalties of perjury, by signing this form, I certify that (1) the number shown on this form is my correct taxpayer identification number, and (2) I am not subject to backup withholding as a result of a failure to report all interest or dividends, or the Internal Revenue Service has notified me that I am no longer subject to backup withholding.

\_\_\_\_\_  
Signature of Claimant\_\_\_\_\_  
Title (Trustee/Executor/Other Title)\_\_\_\_\_  
Date**9. Plan Administrator Certification and Authorization**

Plan Administrator to complete this section. This authorization is required if this this contract is a tax-sheltered 403(b), 401(k) or 457 plan.

Name of Employer Plan	Name of Plan Administrator
-----------------------	----------------------------

The Plan Administrator certifies that the claimant is entitled to benefits under the employer's plan and that the **stream of payments** requested by the claimant is permitted under the employer's plan. The Plan Administrator authorizes the GAIG Company to process the request as indicated above.

\_\_\_\_\_  
Plan Administrator Signature\_\_\_\_\_  
Date

**FRAUD WARNINGS**

**Alabama** A person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines, or confinement in prison, or any combination thereof.

**Alaska** 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.

**Arizona** 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.

**Arkansas** Any person who knowingly presents 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.

**California** For your protection California law requires the following to appear on this form: Any person who knowingly presents a 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.

**Colorado** 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.

**Delaware** 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.

**District of Columbia** WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

**Florida** 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.

**Idaho** Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete or misleading information is guilty of a felony.

**Indiana** A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete or misleading information commits a felony.

**Kansas** Warning: 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 may be guilty of insurance fraud as determined by a court of law and may be subject to fines and confinement in prison."

**Kentucky** 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.

**Louisiana** 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.

**Maine** 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.



**Maryland** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Minnesota** A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

**New Hampshire** Any person who, with a 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 RSA 638:20.

**New Jersey** Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

**New Mexico** 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.

**Ohio** 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.

**Oklahoma** WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

**Oregon** Any person who knowingly and with intent to defraud an insurer makes a claim that contains any false statement or false representation of a material fact or makes a claim that omits or conceals material information may be subject to criminal and civil penalties.

**Pennsylvania** 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.

**Rhode Island** 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.

**Tennessee** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

**Texas** Any person who knowingly presents a 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.

**Virginia** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

**Washington** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

**West Virginia** 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.

**NOTICE TO BENEFICIARIES ABOUT INTEREST**

If required by state law, we will pay interest on the proceeds of the referenced policy or contract for the time period and at the rate required by state law. We will pay interest until we make a lump sum payment or the first installment of a series of periodic payments. Some states require us to provide a specific interest notice to beneficiaries. These notices are set out below. Please contact us at 1-800-854-3649 to find out the applicable interest rate or for more information.

**California** We will pay interest on the proceeds of the referenced policy or contract if we do not pay the proceeds within 30 days of the date of death. We will pay interest from the date of death at the rate required by state law.

**Illinois** We will pay interest on the proceeds of the referenced policy or contract if we do not pay the proceeds within 31 days of the date when we receive due proof of death or such other date as permitted by Illinois law. We will pay interest from the applicable date at the rate of 10%.

**Kansas** We will pay interest on the proceeds of the referenced policy or contract if we do not pay the proceeds within 10 days of the date when we receive due proof of death. We will pay interest from that date at the rate required by Kansas law.

**Minnesota** We will pay interest on the proceeds of the referenced policy or contract from the date of death until the date of payment at the rate required by Minnesota law.

**New Hampshire** We will pay interest on the proceeds of the referenced policy or contract if we do not pay the proceeds within 30 days of the date of death. We will pay interest from the date of death at the rate required by state law.

**Oregon** We will pay interest on the proceeds of the referenced policy or contract if we do not pay the proceeds within 30 days of the date when we receive due proof of death. We will pay interest from the date of death at the rate required by state law.

**South Dakota** We will pay interest on the proceeds of the referenced policy or contract if we do not pay the proceeds within 30 days of the date when we receive due proof of death. We will pay interest from the date of death at the rate required by state law.