



GAIG Member Companies:
Great American Life Insurance Company®
Annuity Investors Life Insurance Company®
Manhattan National Life Insurance Company

Administrator for:
Loyal American Life Insurance Company®
Continental General Insurance Company

Fixed and Fixed Indexed Annuities: PO Box 5420, Cincinnati OH 45201 / 800-854-3649 / 800-482-8126 Fax
Variable and Variable Indexed Annuities: PO Box 5423, Cincinnati OH 45201 / 800-789-6771 / 513-768-5115 Fax
Overnight Address: 10th Floor, 301 E Fourth St, Cincinnati OH 45202

Annuity Payout Benefit

Request to start a stream of payments.

Owner's Name:	Contract/Certificate Number
Primary Address (include City, State and ZIP)*	
Social Security Number	Daytime Phone Number ()
Email Address	Receive email alerts if available? <input type="checkbox"/> Yes <input type="checkbox"/> No Your election will only apply to this request. Email notifications will be sent from 'no-reply@gaig.com'. Please be sure to remove this address from your list of blocked senders.

*If this address differs from what we have on file, we will update our records to reflect what is entered above.

1. Payout Options

Please select one of the following six options (*Options continue on page 2*).

Please contact us if you want an estimate of the payment amount. Once we process your request, you cannot change your payout option. All options may not be available for inherited contracts because of federal tax law restrictions.

<input type="checkbox"/> Payments for a Specified Period. If you die before the end of the specified period, the remaining payments will be made to your contingent payee(s) , which you will name in Section 4 of this form. Check one box below to specify the period over which payments are to be made. Payments for a period of <input type="checkbox"/> 5 years <input type="checkbox"/> 7 years <input type="checkbox"/> 10 years <input type="checkbox"/> 15 years <input type="checkbox"/> ___ years The specified period cannot exceed your life expectancy or any shorter period required by federal tax law.
<input type="checkbox"/> Payments for Life. Payments will continue as long as you live. Please provide proof of your age in the form of a copy of a birth certificate, driver's license, or passport. If your current name does not match this documentation, please also provide proof of name change (marriage certificate, divorce decree, etc.).

See additional Payout Options on page 2 →

- ☐ **Payments for Life with a Minimum Specified Period.** Payments will continue as long as you live. If you die before the end of the minimum specified period, payments for the balance of the minimum specified period will be made to your **contingent payees**, which you will name in Section 4 of this form.

Please provide proof of your age in the form of a copy of a birth certificate, driver's license, or passport. If your current name does not match this documentation, please also provide proof of name change (marriage certificate, divorce decree, etc.).

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

Payments for a minimum
specified period of

☐ 5 years

☐ 7 years

☐ 10 years

☐ 15 years

☐ ___ years

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

- ☐ **Payments for Joint Lives and 50% Survivor.** Payments will continue as long as you live. If you die before the joint payee, he or she will receive 50% of the original payment amount for the rest of his or her life.

Please provide proof of age for you and the joint payee in the form of a copy of a birth certificate, driver's license, or passport. If either of your current names do not match this documentation, please also provide proof of name change (marriage certificate, divorce decree, etc.).

Joint Payee Name:

☐ Male

☐ Female

SSN:

Date of Birth:

Relationship:

- ☐ **Payments for Medicaid Life Expectancy.** If you die before the end of the life expectancy period, the remaining payments will be made to your **contingent payee(s)**, which you will name in Section 4 of this form.

This option is irrevocable, which means that the lump sum value of the payments cannot be surrendered or withdrawn and the payment stream cannot be changed. Payments may not be assigned or transferred.

Please provide proof of your age in the form of a copy of a birth certificate, driver's license, or passport. If your current name does not match this documentation, please also provide proof of name change (marriage certificate, divorce decree, etc.).

In many cases, the State must be the contingent payee for any payments remaining after your death to the extent of any medical assistance paid on your behalf.

In order to process this election, you **MUST** initial below:



Initial Above

By **initialing** in the box to the left, I represent that I have retained **independent legal counsel** to assist with Medicaid eligibility planning and that this payout option is consistent with such Medicaid eligibility plan.

- ☐ **Other payout option** provided by the contract or acceptable to the GAIG member company. Specify requested option below.

2. Payment Frequency

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. If a payment frequency is not marked, monthly payments will be made.

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

3. Types of Distribution and Payee

On some contracts, we are unable to make payments to non-natural persons except for (1) Direct Rollovers specified below, or (2) payments to a plan where a corresponding payment is then owed to the plan participant or beneficiary. **Select one of the three options below and complete *ONLY* that section.**

☐ **Payment to Owner(s)**

We will make payments by check to you until Automatic/Direct Deposit arrangements have been completed. To receive Automatic/Direct Deposit, please fill out the information below.

Financial Institution Name

Note: Attach a voided check, account statement copy, or a letter from your financial institution providing the account owner(s) name(s), routing number and account number.

Type of Account ☐ Checking ☐ Savings

Account Number

Routing Number

Names of all Owners of this Financial Institution Account

I hereby authorize the GAIG member company and the financial institution identified above to deposit my annuity payments into my account identified above, and to adjust my account for any overpayments.

For requests signed by a Power of Attorney or contracts owned by a Trust, see Certification and Authorization Section for additional information.

☐ **Direct Rollover**

For Eligible Rollover Distributions from 403(b) TSAs, 401 Pension/Profit Sharing/401(k) Plans, and Governmental 457 Plans only.

Annuity payment must be a fixed option with a term of less than 10 years. Pursuant to Treasury Regulations Section 1.402(c)-2; Q&A-7, an annuity payment made on or after January 1 of the year the owner will reach age 70½ or retire (whichever is later) is not an eligible rollover distribution and will be paid to the owner.

☐ to Traditional IRA

☐ to 403(b) TSA

☐ to 401 Pension/Profit Sharing/401(k) Plan

☐ to Roth IRA

☐ to Governmental 457 Plan

A letter of acceptance from the new trustee, custodian, or insurer MUST be provided.

Financial Institution Name

Account Number

Street Address

City, State, ZIP

☐ **Payment to Annuitant (if different than the owner)**

For Non-Qualified contracts, tax reporting is to the owner and the owner will retain the right to change the payee unless you waive that right in writing. If you waive that right, you will be immediately taxed for the entire taxable portion of the contract.

Annuitant Name

Current Street Address

City, State, ZIP

4. Contingent Payee Designation

This section applies only to **Payments for a Specified Period, Payments for Life with a Minimum Specified Period and Payments for Medicaid Life Expectancy**. **Skip to Section 5** if you have selected *Payments for Life* or *Payments for Joint Lives and 50% Survivor*. Under the payout option, payments may extend beyond your life. The beneficiary section of the contract no longer applies. Subject to any contingent payee designation made by the owner, 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, phone, relationship to you, and payee's 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.

For requests signed by a Power of Attorney or contracts owned by a Trust, see Certification and Authorization Section for additional information.

Contingent Payee Designation	
Percentage _____%	Percentage _____%
Name _____	Name _____
Address _____	Address _____
City _____ State _____ ZIP _____	City _____ State _____ ZIP _____
SSN/EIN _____ Relationship _____	SSN/EIN _____ Relationship _____
Date of Birth _____ Phone No. _____	Date of Birth _____ Phone No. _____
Email Address _____	Email Address _____
Percentage _____%	Percentage _____%
Name _____	Name _____
Address _____	Address _____
City _____ State _____ ZIP _____	City _____ State _____ ZIP _____
SSN/EIN _____ Relationship _____	SSN/EIN _____ Relationship _____
Date of Birth _____ Phone No. _____	Date of Birth _____ Phone No. _____
Email Address _____	Email Address _____

*If you need additional space to name payees, please attach an additional page that is **signed and dated** by you.*

Caution for Payments for Medicaid Life Expectancy: If you do not name your State as the contingent payee, you may not qualify for Medicaid benefits.

5. Income Tax Withholding

Federal Withholding - For distributions to the annuitant/participant of a 403(b) TSA, 401 Pension/Profit Sharing/401(k) Plan, or a Governmental 457 Plan, a minimum of 20% federal income tax withholding is required by law unless your distribution is made under a life option or a fixed option of 10 years or more, or you are 70 ½ or above.

For all other distributions, federal tax withholding is not mandatory. If a withholding election is not indicated or if you choose to have taxes withheld but a percentage is not indicated, federal tax withholding will be based on tables for a married taxpayer with three exemptions (which excludes approximately \$24,000 per year from withholding).

☐ Withhold the following federal income tax from my payments (or any mandatory amount, if greater):
\$ _____ or _____ %

☐ Do not withhold federal income tax from my payments, unless mandatory.

State Withholding - If federal withholding is elected, state withholding may also apply due to state requirements. State withholding may be elected for other states, if permitted.

☐ Withhold the following state income tax from my payments (or any mandatory amount, if greater):
\$ _____ or _____ %

☐ Do not withhold state income tax from my payments, unless mandatory.

NOTE: Withholding will only apply to the taxable portion of your distribution. Whether or not federal and state income tax is withheld, you are liable for payment of all applicable federal and/or state income taxes on the taxable portion of the distribution. You may also be subjected to penalties under the estimated tax payment 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 the GAIG member company in writing at any time.

6. Special Tax Notice Regarding Plan Payments

The Special Tax Notice contains information about rollover rights and tax treatment of eligible rollover distributions from a 403(b) TSA plan, a 401 Pension/Profit Sharing/401(k) plan, or a Governmental 457 plan. It is provided for your information. Please contact our office prior to submitting this form if your contract is under one of these plans and you did not receive the Special Tax Notice.

For eligible rollover distributions from these plans, you have 30 days to consider your options.

Unless you check the box below, we will hold your request for this 30-day consideration period.

☐ I waive my 30-day consideration period.

7. 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 I have taken all RMDs for *this* contract for the current year and all prior years in whole or in part from another permitted source.

8. For 403(b) TSA Contracts Only

If you do not have a 403(b) TSA, this section does not apply. I certify that these payments requested from my 403(b) TSA contract are permitted as a result of (**MUST CHECK ONE**):

- ☐ **AGE 59½:** I am now age 59½ or older
- ☐ **SEVERANCE FROM EMPLOYMENT:** I have severed employment with the employer through which 403(b) TSA contributions were made.
Date of severance: _____ Name of employer: _____
- ☐ **DISABILITY:** I am unable to engage in customary or comparable substantial gainful activity by reason of medically determinable physical or mental impairment expected to result in death or be of long-continued and indefinite duration.
Attach documentation if no plan administrator.
- ☐ **QDRO:** Payments will be made to an alternate payee under a qualified domestic relations order. **Attach copy of court order.**
- ☐ **CONTRACT EXCHANGE:** Payments will be made as a contract exchange within the same employer 403(b) TSA plan. **If permitted by annuity contract.**
- ☐ **ROLLOVER ACCOUNT:** My contract was solely funded with employer contributions.
- ☐ **EMPLOYER CONTRIBUTIONS:** Must check one:
- ☐ My contract was issued on or before 12/31/08.
- ☐ The payment is permitted based on occurrence of event specified by plan document.

9. Owner/Annuitant/Participant Certification and Authorization

I understand that:

- All rights and benefits under any living benefit, death benefit, or other rider attached to my contract will end.
- Unless made in the form of a direct rollover, distributions before age 59½ may be subject to a 10% federal penalty tax (or 25% for some SIMPLE IRA distributions) in addition to other applicable income taxes.

I agree and certify that the GAIG member company is authorized to process this request for an annuity payout benefit, agree that all payments will be subject to the terms and conditions of the annuity contract, and agree to hold the GAIG member company harmless against any and all claims made by reason of compliance with this request.

Signature of Owner/Annuitant/Participant

Date

Signature of Joint Owner (if applicable)

Date

For requests signed by a Power of Attorney (POA):

- We must receive a copy of the POA document.
- The POA Certification (form AAG2816) must also be completed or on file.
- Payments can only be made to an account where the person who gave the POA is a named owner of the account.
- Payment will be made to the Principal and not to the Attorney in Fact.
- A Contingent Payee designation naming the Attorney in Fact will be subject to additional review.

For contracts owned by a Trust:

- The acting Trustee(s) must sign.
- Payments can only be made to an account owned by the Trust unless additional documentation is provided showing that these distributions from the Trust are permitted.
- A Trust may not name a Contingent Payee unless additional documentation is provided.
- If there has been a change of Trustee(s) from the Trustee(s) on file, then you must submit a new Trust Certification (form X6017907NW).

Log into **GAIGannuities.com** if you need the POA or Trust Certification form.

10. Plan Administrator Certification and Authorization (only applicable to 403(b) TSA, 401 Pension/Profit Sharing/401(k) or 457 tax qualified contracts)

Plan Administrator to complete this section.

Name of Employer Plan	Name of Plan Administrator	Plan Administrator Phone ()
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The Plan Administrator certifies that the annuity payout benefit is permitted under the employer's plan. The Plan Administrator authorizes the GAIG member company to process the request as indicated above.

Plan Administrator Signature

Date

11. Signature Notarization or Signature Guarantee (if applicable)

Your signature on this Annuity Payout Benefit request must be notarized or signature guaranteed below **ONLY** if:

- Requested by the home office; or
- You purchased the contract electronically with an e-signature and you have not previously submitted a notarized or guaranteed signature.

Option 1: Notarized Signature

State of	County of
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Acknowledged before me this _____ day of _____ in the year _____ by
(name)_____

Signature of Notary Public
SEAL

My Commission expires (MM/DD/YYYY)

Option 2: Signature Guarantee

SIGNATURE GUARANTEED BY: Stamp or Seal of Eligible
Guarantor Institution with Authorized Signature

You may have signature guarantee provided by a bank, savings and loan association, trust company, credit union, broker/dealer or any other "eligible guarantor institution" as defined under the rules adopted by the Securities and Exchange Commission. These institutions often participate in signature guarantee medallion programs such as the Securities Transfer Agent Medallion Program (STAMP).