

# DEFERRED ANNUITY CLAIM FORM

## EquiTrust Life Insurance Company®

7100 Westown Parkway, Suite 200  
West Des Moines, Iowa 50266-2521  
(866) 598-3692 Fax: (515) 226-5101  
[www.EquiTrust.com](http://www.EquiTrust.com)

Mailing Address: PO Box 14500  
Des Moines, Iowa 50306-3500

### 1. ANNUITY CONTRACT NUMBERS - One form may be used for multiple Contracts, unless different Payment Options are selected.

List all annuity Contract number(s) for which you are claiming death benefits:

### 2. INFORMATION ABOUT THE DECEASED

Decedent's Name			Also Known As (if applicable)	
Date of Birth	Date of Death	Country Where Death Occurred	Decedent's Social Security Number	
<ul style="list-style-type: none"><li>One certified death certificate is required, showing cause and manner of death.</li><li>If death occurred outside the United States, a U.S. Consular's Report of the Death of an American Citizen is required.</li></ul>				

### 3. BENEFICIARY INFORMATION - In what capacity are you claiming the death benefit? Mark appropriate box.

<input type="checkbox"/>	<b>Beneficiary (individual)</b> – Complete one form for each Beneficiary.
<input type="checkbox"/>	<b>Trustee</b> – Complete the Trust Information/Certification, form ET-Trust-2502. Contact our office to request this form.
<input type="checkbox"/>	<b>Executor, administrator or personal representative</b> – Include court certificate of appointment. Complete the form with the estate information rather than your personal information. The claim is payable to the estate.
<input type="checkbox"/>	<b>Charity or corporation</b> – Complete the Entity Certification and Indemnification Agreement, form ET-ENTITY-2503.
<input type="checkbox"/>	<b>On behalf of a minor child as attorney-in-fact or as custodian or guardian</b> – Include appropriate documentation.
<input type="checkbox"/>	<b>Foreign Beneficiary</b> – Natural person: include a completed and signed IRS Form W-8BEN.
<input type="checkbox"/>	<b>Spouse of decedent</b>
<input type="checkbox"/>	<b>Other:</b> _____

### 4. BENEFICIARY CONTACT INFORMATION

Beneficiary Name/Name of Estate/Charity/Corporation			Also Known As (if applicable)	
Date of Birth (mm/dd/yy)		Social Security / Tax Identification Number (TIN)		Phone Number
Street Address		City	State	Zip Code
Mailing Address (if different than above)		City	State	Zip Code
Email Address		Relationship to Deceased		

**5. PAYMENT OPTIONS** - Select one Payment Option only. Please be aware that upon distribution of funds, you will need to include the taxable portion of the distribution in your gross income for tax purposes. Consider your options carefully. Consult your financial or tax advisor before making your decision.

<input type="checkbox"/>	<p><b>Lump Sum</b> See Section 8 for Federal and State Income Tax Withholding (if applicable). <b>Note:</b> Electronic Funds Transfer (EFT) is not available for Lump Sum payments.</p>
<input type="checkbox"/>	<p><b>Payout Option – Distributions must begin no later than one year after the deceased’s date of death.</b> <b>Note: For ineligible beneficiaries of a qualified IRA where date of death is 1/1/2020 or after, the duration of the payout may not be more than 10 years. See definition of ineligible beneficiary on the Stretch/Inherited IRA election form. (Form No. ET2536(5-20))</b></p> <p><b>Option:</b> <input type="checkbox"/> Life* <input type="checkbox"/> Fixed Period Duration (minimum of 5 years, maximum of 20 years): _____ <b>*If a Life Contingency Option is selected, you must provide proof of age (copy of unexpired driver’s license, passport, etc.)</b></p> <p><b>Payment Start Date:</b> (Specify the month and date of the first payment. Available dates are the 1<sup>st</sup> through 28<sup>th</sup>) Month/Day/Year _____</p> <p><b>Frequency**:</b> <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Annual **If any frequency other than Annual is chosen, the Automatic Deposit Authorization Form ET-2513 is required.</p> <p>Complete Section 6 <i>My Beneficiary (ies)</i>.</p>
<input type="checkbox"/>	<p><b>Spousal Continuation with EquiTrust Life Insurance Company</b> Option is available only if you are the spouse of the deceased and the sole primary Beneficiary of the annuity. <b>Note:</b> You are electing to continue the existing Contract in your name. This Contract will continue in force with the original effective date. Upon your death, the Beneficiary that you elect in Section 6 - My Primary Beneficiary(ies) will receive the funds.</p>
<input type="checkbox"/>	<p><b>Spousal 1035 Exchange – Non-qualified Annuity</b> Option is available only if you are the spouse of the deceased and the sole primary Beneficiary of the non-qualified annuity. This election is only available when submitting the Deferred Annuity Claim Form for the first time.</p> <p><input type="checkbox"/> 1035 Exchange paperwork included <input type="checkbox"/> 1035 Exchange paperwork to follow</p>
<input type="checkbox"/>	<p><b>Non-Qualified Stretch Transfer (non-spouse only)</b> Option is available only if you are transferring the money to another annuity provider.</p> <p>A non-qualified stretch is available for non-qualified annuity contracts only. The stretch option must be elected with the new annuity provider, and the first required minimum distribution must be taken prior to the 1-year anniversary of date of death. (Per IRS guidelines)</p> <p><b>NOTE:</b> It is understood that any current and future required minimum distributions are your responsibility in cooperation with your new annuity provider. EquiTrust Life will not distribute such required minimum distributions nor assume responsibility for any failure to meet this requirement. Contact your tax advisor with any questions.</p> <p><input type="checkbox"/> Transfer paperwork included <input type="checkbox"/> Transfer paperwork to follow</p>
<input type="checkbox"/>	<p><b>Qualified Stretch/Inherited IRA Transfer with EquiTrust Life Insurance Company</b> Available for qualified Contracts only and must be elected by Dec. 31<sup>st</sup> of the year following the date of death.</p> <p><b>Note:</b> Additional Stretch/Inherited IRA Election Form, (Form #ET-2536 Election to Stretch/Inherit an IRA) is required. Please contact our office prior to submitting the Deferred Annuity Claim Form for the additional forms. To properly complete the Stretch/Inherited IRA Election Form beneficiary eligibility must be determined. See form for definitions.</p> <p>Complete Section 6 <i>My Beneficiary(ies)</i>.</p>

<input type="checkbox"/>	<p><b>Qualified Stretch/Inherited IRA Transfer</b>  Available for qualified Contracts only and must be elected by Dec. 31<sup>st</sup> of the year following the date of death.</p> <p><b>Note:</b> This option is used to transfer the death benefit to a Stretch/Inherited IRA with another annuity provider.  <b>Election of this option is dependent on beneficiary eligibility as it pertains to the 2019 SECURE Act. Please consult your tax advisor or new carrier.</b></p> <p><input type="checkbox"/> Transfer paperwork included. OR <input type="checkbox"/> Transfer paperwork to follow</p> <p><input type="checkbox"/> Please process my Required Minimum Distribution (RMD) if not previously taken before processing the transfer.</p> <p>NOTE: Check this box only if the death occurred in 2019. If the death occurred in 2020, the beneficiary RMD's are no longer applicable pursuant to the 2019 SECURE Act.</p>
<input type="checkbox"/>	<p><b>5 Year Deferral Election of Payment –</b></p> <p><b>This Option is available for all deferred Non-Qualified contracts and for deferred Qualified contracts with death prior to 2020.</b></p> <p><input type="checkbox"/> Defer lump sum payout until the 5<sup>th</sup> anniversary of date of death</p>
<input type="checkbox"/>	<p><b>10 Year Deferral Election of Payment –</b></p> <p><b>This Option is available for Qualified contracts for deaths in 2020 and later</b></p> <p><input type="checkbox"/> Defer lump sum payout until the 10th anniversary of date of death</p>
<input type="checkbox"/>	<p><b>Other:</b> _____</p> <p>_____</p>

**6. MY BENEFICIARY(IES)** - Complete this section if you selected Payout Option, Stretch/Inherited IRA with EquiTrust or Spousal Continuation in Section 5. Percentages for all Beneficiaries must total 100%. Primary and Contingent Beneficiaries may be named.

<b>Primary</b>	Share %	Relationship
Individual, Trust or Company Name	SSN/TIN	
	Birth Date	Phone Number
Address, City, State, Zip		
E-mail		
<input type="checkbox"/> <b>Primary</b> <input type="checkbox"/> <b>Contingent</b>	Share %	Relationship
Individual, Trust or Company Name	SSN/TIN	
	Birth Date	Phone Number
Address, City, State, Zip		
E-mail		
<input type="checkbox"/> <b>Primary</b> <input type="checkbox"/> <b>Contingent</b>	Share %	Relationship
Individual, Trust or Company Name	SSN/TIN	
	Birth Date	Phone Number
Address, City, State, Zip		
E-mail		
You may use additional pages completed with Beneficiary information, signed and dated on each sheet. Include the word "Attachment" and the Contract number on each additional sheet.		
<input type="checkbox"/> If you need more space and have attached additional sheets to your form, please check this box.		

**7. FOREIGN BENEFICIARY**

**Beneficiary is NOT a United States citizen (Foreign Beneficiary)** – If the Beneficiary is not a United States Citizen, the Company is required to withhold up to 30% of any gain and/or interest from the benefit payable to the Beneficiary. A special withholding rule exists if the Beneficiary is a citizen of, and resides in, a country with which the United States has an income tax treaty. A list of treaty countries provided in IRS Publication 901 (United States Tax Treaties) which can be obtained from the IRS website at [www.IRS.gov](http://www.IRS.gov) or from an IRS office in the Beneficiary's country of residence. In order for the Company to institute a lower treaty rate, the Beneficiary's United States Taxpayer Identification Number (TIN) must be provided.

- If the Beneficiary does not have a United States TIN, one can be obtained from the Internal Revenue Service by using IRS Form W-7 (Application for IRS Individual Taxpayer Identification Number).  
**NOTE: The Company does not facilitate the Beneficiary's application for a TIN. Please do not return IRS Form W-7 to our office.**
- If all other documents necessary to settle the claim(s) have been provided, the Company will proceed with settlement of the claim and withhold 30% of the gain and/or interest.
- **Foreign Beneficiary (Natural Person):** A completed and signed IRS Form W-8BEN, (Certificate of Foreign Status of a Beneficial Owner for United States Tax Withholding) must be provided.
- **Foreign Beneficiary (Entity):** The claim form must be signed by an authorized representative of the organization. A copy of the corporate resolution, bylaws or other documents verifying that signer(s) of the claim form are authorized to act on behalf of the organization must be provided.  
A completed and signed IRS Form W-8-IMY (Certificate of Foreign Intermediary, Foreign-Through Entity, or Certain U.S. Branches for United States Tax Withholding) must be provided.

## 8. TAX WITHHOLDING

The Internal Revenue Service (IRS) requires that you complete the following section:

**Note:** If a federal withholding option is not selected, a 10% federal income tax will be automatically withheld.

**FEDERAL**     No, I do not want to have Federal Income Tax withheld from my payments  
 Yes, I would like the following Federal Income Tax withheld: \$ \_\_\_\_\_ or \_\_\_\_\_ %.

**STATE\***       No, I do not want to have State Income Tax withheld from my payments  
 Yes, I would like the following State Income Tax withheld: \$ \_\_\_\_\_ or \_\_\_\_\_ %.

**\*Certain states require the Company to withhold state income taxes. If you live in one of those states, state income tax will be withheld from your distribution in addition to any federal tax withholding.** State withholding is based on the Street Address indicated on page 1. If you file taxes in a state other than what is on page 1, indicate that state here: \_\_\_\_\_

If you elect not to have withholding apply to your distribution, or if you do not have enough tax withheld, you may be responsible for payment of estimated tax. You may also be subject to tax penalties under the estimated tax rules if your withholding and estimated tax payments are not sufficient.

## 9. CERTIFICATION OF TAXPAYER IDENTIFICATION NUMBER

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct Taxpayer Identification Number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or U.S. resident for tax purposes.

**NOTE: The IRS does not require your consent to any provision of this document other than the certification above.**

## 10. NEW YORK NOTICE

**Residents of NY: 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.**

## 11. LOST CONTRACT

I certify that this Contract has been lost or destroyed and that it was not assigned, hypothecated, or pledged in any way whatsoever. I agree that should the original Contract be found or in any way come into my possession, it will immediately be returned to EquiTrust. It is expressly understood that after payment of death benefit, the original Contract shall become null and void. I agree to indemnify EquiTrust against any loss that may be sustained as a result of having paid this claim.

**12. REQUIRED SIGNATURES – BENEFICIARIES** - As the Beneficiary, trustee(s), executor(s), legal guardian, custodian, attorney-in-fact, or signing officer, please sign your name and date below. **If you do not sign and date below, processing of your claim will be delayed.**

By signing below, you are confirming that you have reviewed the applicable state fraud notice at the end of the form.

- If signing on behalf of a Trust you must complete the Trust Information/Certification, form ET-TRUST-2502
- If a Trust and the named trustee is a company/corporation, the person(s) signing below on behalf of the corporate trustee are duly authorized by the company/corporation to do so.

Signature	Title (if Trust or Corporation)	Date (mm/dd/yy)
Signature	Title (if Trust or Corporation)	Date (mm/dd/yy)

If you are signing on behalf of the Beneficiary, check one of the boxes to indicate the capacity in which you are signing and provide documentation to verify your authorization to act on behalf of the Beneficiary.

**SIGNATURE MUST BE NOTARIZED.**

Conservator    Guardian    Power of Attorney    Executor

Signature	Name (please print)			Date (mm/dd/yy)
Street Address	City	State	Zip	Phone Number

**Notary Signature Section**

STATE OF \_\_\_\_\_

COUNTY OF \_\_\_\_\_

Subscribed and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

Notary Public Signature\* \_\_\_\_\_

Notary Public Printed Name \_\_\_\_\_

\*Note: Per EquiTrust Business Guidelines, agents may not act as notary on client's financial transactions.

My Commission Expires \_\_\_\_\_

## FRAUD NOTICES

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**Important:** This is part of the Annuity Claim Form. Please review the applicable fraud notice for your State below.

**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.

**AL-** Any 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.

**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.

**AR, DC, LA, RI, 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.

**CA-**For you 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."

**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.

**DE and ID -** 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 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.

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

**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.

**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.

**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.

**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 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.

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

**FRAUD NOTICES CONTINUE ON THE NEXT PAGE**

**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 false or deceptive statement is guilty of insurance fraud.

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

**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.

**TX** - 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.

**For All Other States** - Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or settlement 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.



**AUTOMATIC DEPOSIT  
AUTHORIZATION AGREEMENT**

**EquiTrust Life Insurance Company®**

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**NOTE: If automatic deposit is already established on this Policy/Contract, use this form only to revise or update bank account information.**

Owner Name	Policy/Contract Number
Joint Owner Name	Phone Number
Policy/Contract Type <input type="checkbox"/> Life Insurance Policy <input type="checkbox"/> Annuity Contract	

**AGREEMENT**

I hereby authorize EquiTrust to make direct deposits to my account and for the bank named below to accept these deposits. I also authorize EquiTrust to make withdrawals from this account in the event that a credit entry is made in error.

This authority is to remain in force until EquiTrust has written notification from me of its termination in such time and in such manner as to afford EquiTrust a reasonable opportunity to act on it.

**BANK INFORMATION**

Bank Owner Name (as it appears on the account)		Bank Joint Owner Name (as it appears on the account)		
Owner Social Security Number		Joint Owner Social Security Number		
Account Owner Signature	Date	Joint Owner Signature	Date	
EquiTrust Owner Signature		EquiTrust Joint Owner Signature		
Account Information <input type="checkbox"/> Checking <input type="checkbox"/> Savings Must be checking or savings account, no money market or brokerage accounts				
Bank Name				
Street Address		City	State	Zip
Bank Routing Number (9 digits)		Bank Account Number		

**IMPORTANT NOTES**

- Amounts greater than \$50,000 must be distributed via check.
- The electronic transfer of funds may take 2-3 business days to reach your account once funds are released from our office and is subject to your bank processing time.