

ANNUITY CLAIMANT STATEMENT

Aurora National Life Assurance Company

Mailing Address

P.O. Box 4336

Clinton IA 52733-4336

Proof of Loss Part I

INSTRUCTIONS

The following items are required for all claims:

- **A copy of the death certificate showing cause of death.**
- **This claim form completed and signed by the claimant(s).**

If the death occurred outside of the United States, we will require a Report of the Death of an American Citizen Abroad.

Special Instructions and additional requirements may apply.

- **If the beneficiary is the Estate of the Insured**, we will also require evidence of the court appointed legal representative over the estate. Please provide the Tax ID number of the Estate of the Insured.
- **If the beneficiary is a trust**, we will also require a copy of the trust agreement and any amendments, including the signature page(s). Please note the Trustee Certification section of the claim form will also need to be completed by all trustees. Please use the trust's name when completing the Claimant Information section of the claim form and provide the Tax ID number of the trust.
- **If the beneficiary is a minor**, we will require evidence of court appointed guardianship of the Minor's Estate.
- **If the contract is collaterally assigned**, we will require a letter from the collateral assignee stating the balance due under the collateral assignment. If the collateral assignee is a corporation, please include a copy of the corporate resolution verifying who is authorized to sign on behalf of the corporation.
- **If the primary beneficiary(ies) is (are) deceased**, we will require a death certificate for each deceased beneficiary.
- **If the contract has a split dollar agreement associated with it**, we will require a copy of said agreement.

Other requirements may be needed depending on the individual facts of the claim. The company will advise you if other documentation is required.

FRAUD INFORMATION

For Residents of Alaska, Arizona, Nebraska, New Hampshire, and Oregon: 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 a crime and may be subject to fines and confinement in prison.

For Residents of California: For your protection California law requires the following notice 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 prison.

For Residents of 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 in 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.

For Residents of 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.

For Residents of Kentucky, Ohio and Pennsylvania: Any person who knowingly & 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 hereto commits a fraudulent insurance act, which is a crime & subjects such person to criminal and civil penalties.

For Residents of Maine, Tennessee, and 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.

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

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

For Residents of 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.

For Residents of New York: Please see the Signatures section of this form.

For Residents of Puerto Rico: Any person who, knowingly and with intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

For Residents of All Other States: 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.

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DECEDENT INFORMATION

1. Name of Deceased (Last, First Middle)		2. Last 4 digits of Deceased's Social Security No:	
3. If the Deceased was known by any other names, such as maiden name, hyphenated name, nickname, derivative form of first and/or middle name or an alias, please provide them below.			
4. Contract Number(s)		5. If contract is lost or not available, please explain:	
6. Deceased's Date of Death	7. Cause of Death	8. ☐ Natural ☐ Accidental ☐ Pending ☐ Suicide ☐ Homicide	

CLAIMANT INFORMATION

9. Claimant Name (Last, First, Middle). If trust, please list trust name and complete Trustee Certification section.			
10. Street Address	11. City	12. State and Zip	13. Daytime Phone Number
14. Date of Birth	15. Social Security or Tax ID Number		16. Relationship to Deceased
17. I am filing this claim as: ☐ an individual who is named as a beneficiary under the policy ☐ a Trustee of a Trust which is named as a beneficiary under the policy ☐ an Executor of Estate which is named as a beneficiary under the policy ☐ Other			
18. Are you a U.S. Citizen? ☐ Yes ☐ No If "No" please list country of citizenship _____			
19. Federal tax law requires us to withhold 10% of the taxable gain from your claim payment unless you tell us that you do not want federal income taxes withheld. In addition, certain state tax laws require that we withhold state income taxes if federal income taxes are withheld. Montana residents may elect (but are not required) to withhold a flat dollar amount. ☐ DO NOT withhold federal income tax; or ☐ Withhold _____% or \$_____ for federal income tax (choose either a percent or flat amount, but not both)			

CLAIMANT INFORMATION (to be completed by 2nd claimant, if any)

20. Claimant Name (Last, First, Middle). If trust, please list trust name and complete Trustee Certification section.			
21. Street Address	22. City	23. State and Zip	24. Daytime Phone Number
25. Date of Birth	26. Social Security or Tax ID Number		27. Relationship to Deceased
28. I am filing this claim as: ☐ an individual who is named as a beneficiary under the policy ☐ a Trustee of a Trust which is named as a beneficiary under the policy ☐ an Executor of Estate which is named as a beneficiary under the policy ☐ Other			
29. Are you a U.S. Citizen? ☐ Yes ☐ No If "No" please list country of citizenship _____			
30. Federal tax law requires us to withhold 10% of the taxable gain from your claim payment unless you tell us that you do not want federal income taxes withheld. In addition, certain state tax laws require that we withhold state income taxes if federal income taxes are withheld. Montana residents may elect (but are not required) to withhold a flat dollar amount. ☐ DO NOT withhold federal income tax; or ☐ Withhold _____% or \$_____ for federal income tax (choose either a percent or flat amount, but not both)			

YOUR SIGNATURE IS REQUIRED ON THE NEXT PAGE

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SETTLEMENT OPTIONS

The contract may contain one or more settlement options, such as Payments for a Fixed Period of Time, Life Income, Payments for a Fixed Amount, or Joint Life Income. You may choose to receive a lump sum payment or another settlement option available in the contract under which a claim is made. For more information, refer to the Settlement Options provision in the contract or contact us at the mailing address noted on the front of the claim form.

If you wish to select a settlement option, please indicate your settlement selection by name (not by number) on the line below after you have carefully reviewed the options available in the contract. Availability of settlement options are subject to the terms of the contract. If you do not choose a settlement option, we will send a lump sum settlement to you.

Name of Settlement Option from Contract

Important Information About the USA PATRIOT Act

To help fight the funding of terrorism and money-laundering activities, the U.S. government has passed the USA PATRIOT Act, which requires banks, including our processing agent bank, to obtain, verify and record information that identifies persons who engage in certain transactions with or through a bank. This means that we will need to verify the name, residential or street address (no P.O. Boxes), date of birth and social security number or other tax identification number of all account owners.

SUBSTITUTE FOR IRS FORM W-9

This information is being collected on this form versus IRS form W-9 and will be used for supplying information to the Internal Revenue Service (IRS). Under penalty of perjury, I certify that 1) the tax ID number above is correct (or I am waiting for a number to be issued to me), 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 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 because you have failed to report all interest and dividends on your tax return.

SIGNATURES

I/We do hereby make claim to said insurance, declare that the answers recorded above are complete and true, and agree that the furnishing of this and any supplemental forms do not constitute an admission by the Company that there was any insurance in force on the life in question, nor a waiver of its rights or defenses.

For Residents of New York: Any person who knowingly and with intent to defraud any insurance company or other person who 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, 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.

For Residents of All Other States: See the Fraud Information section of this claim form.

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

Signature of Claimant and Title

Date

Signature of Second Claimant, if any, and Title

Date

ANNUITY CLAIMANT STATEMENT

TRUSTEE CERTIFICATION

TRUSTEE CERTIFICATION (to be completed only if trust is claiming proceeds)

COMPLETE THIS SECTION ONLY IF A TRUST IS CLAIMING BENEFITS.

Please include a copy of the trust agreement, including the signature page(s) and any amendments.

I/We, the undersigned trustee(s), represent and warrant that the copy of the trust agreement, which we will provide you pursuant to this certification, is a true and exact copy of said agreement, that said agreement is in full force and effect, and that we have the authority to make this certification.

Generation Skipping Transfer Tax Information – THIS MUST BE COMPLETED FOR PAYMENT

I/We the undersigned, on oath, deposes and states as follows with respect to the possible application of the Generation Skipping Transfer (GST) tax to the death benefit payment (Mark the appropriate item):

____ 1. The GST tax does not apply because the death benefit is not included in the decedent's estate for federal estate tax purposes.

____ 2. The GST tax does not apply because the GST tax exemption will offset the GST tax.

____ 3. The GST tax does not apply because at least one of the trust beneficiaries is not a "skipped" person.

____ 4. The GST tax does not apply because of the reasons set forth in the attached document (Please attach document settling forth the reasons why you believe the GST tax does not apply.)

____ 5. The GST tax may apply. As a result, the death benefit payment IS subject to withholding of the applicable GST tax. Enclosed is the completed Schedule R-1 (Form 706) for submission to the Internal Revenue Service.

Name of Trust	Date of Trust Agreement
Date of all Amendments	Trust Tax ID Number
Printed Name of Trustee(s)	Signature(s)
a _____	_____
b _____	_____
c _____	_____
d _____	_____