AURORA
AN RGA COMPANY

PAYMENT AUTHORIZATION

Aurora National Life Assurance Company • PO Box 4336, Clinton, IA 52733-4336 • Telephone (800) 265-2652

This form should be completed by an authorized representative of the Plan to initiate the payment process for a payee under the Group Contract, or change the data for a Participant. Any benefit amounts listed on this form are subject to verification. Any benefit amounts payable will be provided by the group contract. Any changes are subject to company approval and may require an adjustment to the premium. Please return to the attention of Institutional Markets at the address above.

NAME OF PLAN	GROUP NUMBER	DATE

PARTICIPANT DATA

NAME	CONTRACT NUMBER	SOCIAL SECURITY NUMBER

ADDRESS	CITY	STATE	ZIP CODE

DATE OF BIRTH	DATE OF HIRE	DATE OF TERMINATION

Indicate the purpose of your request and provide all requested information

☐ Process death benefit. (*Attach a copy of the original death certificate to this form and complete Payee information section below.*)

a. The Participant died on _____
b. Amount of death benefit payable $_____
c. Benefit payable to: ☐ Beneficiary ☐ Surviving Spouse ☐ Joint Annuitant
d. Benefit effective date _____

☐ Initiate payments to retire. *(Please complete the Payee Information section below.)*

a. Participant's retirement date _____ / _____ / _____
b. Amount of benefit payable $_____
c. Benefit payable to: ☐ Participant ☐ Beneficiary ☐ Surviving Spouse ☐ Joint Annuitant
d. Will there be a cash withdrawal paid to Participant? ☐ Yes ☐ No
   1. If "yes," amount of cash withdrawal $ _____
   2. Employee contribution payable $ _____
   3. Employer contribution payable $ _____
   4. Amount of interest through ___/___/___ $ _____
   5. Total distribution $ _____

PAYEE INFORMATION (Please complete for the person who is to receive benefit payments.)

NAME	SOCIAL SECURITY NUMBER

ADDRESS	CITY	STATE	ZIP CODE

TELEPHONE NUMBER	DATE OF BIRTH	RELATIONSHIP TO ANNUITANT

☐ Change Participant's benefit amount.

a. Reason for change: ☐ Cost of living adjustment

☐ Social Security adjustment option

☐ Other: _____

_____

b. Change benefit amount from $ _____ to $ _____

☐ Change employee group insurance deduction.

a. Please make the following change as authorized by the Participant in writing.
   ☐ Change insurance amount to $ _____
b. Insurance deduction changes should be effective ____ / ____ / _____
c. Other *(please specify and include all necessary information.)*

_____

_____

☐ Other *(Use this section if there is no other section which pertains to your request. Please specify and include all necessary information. Attach separate sheet if necessary.)*

_____

_____

_____

_____

_____

_____

SIGNATURE

This election serves as the basis for a supplemental contract and supercedes all previous designations. Once annuitized, the supplemental contract is not surrenderable nor can the benefits be changed. Following completion of all requirements the requested changes made by the application constitute a supplemental to the original application for the Annuity and shall form a part of the Annuity.

AUTHORIZED REPRESENTATIVE'S SIGNATURE	DATE