



Nassau Life and Annuity Company
 Nassau Life Insurance Company
 PHL Variable Insurance Company
 PO Box 219361, Kansas City, MO 64121-9361
 Fax: 816-221-9674

**Request for Systematic Withdrawal
 (Prior to Annuitization)**

Note: This form is NOT used to request a Required Minimum Distribution or Substantially Equal Periodic Payments.

Contract Number	Contract owner (print name)	Joint Owner Name, if applicable
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1. Amount of Systematic Withdrawal (Complete in all cases.)

a. Fixed Rate Annuity

- Annual earnings or interest amount, capped at the amount available without surrender charges (as described in the contract)
- Fixed Amount \$ _____, capped at the amount available without surrender charges
- Fixed Amount \$ _____, not capped

b. Variable Rate Annuity

- Fixed Amount \$ _____, capped at the amount available without surrender charges
- Fixed Amount \$ _____, not capped
- Maximum amount available under the "Guaranteed Minimum Withdrawal Benefit (GMWB)" Rider

c. Indexed Annuity

- Fixed Amount \$ _____, capped at the amount available without surrender charges
- Fixed Amount \$ _____, not capped
- Maximum amount available under the Living Benefit Rider (such as GMWB)

If your Guaranteed Lifetime Withdrawal Benefit includes a Return of Premium Death Benefit, that death benefit feature will be terminated if you withdraw an amount greater than your Death Benefit Guarantee Withdrawal Threshold Amount in any Rider Year. We will contact you if this withdrawal will terminate the Return of Premium Death Benefit, requiring you to complete an additional form acknowledging the termination before we process your withdrawal. Contract Owners may also contact us prior to requesting a withdrawal to obtain information concerning whether a requested withdrawal will impact their death benefit. Upon termination of the Return of Premium Death Benefit, there will be no reduction in the rider fees.

Withdrawals will automatically be deducted per your contract default.

NOTE: Withdrawals in excess of the guaranteed withdrawal amount as set forth in the Living Benefit Rider (including GMWB), may be "excess withdrawals" under such Rider and will result in a permanent reduction in future benefits under the Rider. Contract Owners may contact us prior to requesting a withdrawal to obtain information concerning whether a requested withdrawal will impact the benefits.

2. Payment Method/Frequency: (Please select one (1) Frequency and one (1) Method.) If nothing is checked, Monthly will apply.

Frequency: Monthly (Direct Deposit only) Quarterly Semi-Annually Annually

To begin: ____/____/20__ (Note: Must be on or after next monthly anniversary. If left blank will begin on next monthly anniversary.)

Method of Distribution: - Check one of the payment methods listed below. (If none checked, will be mailed to the address of record).

- Check mailed to address of record.
- Direct Deposit. Please return the Direct Deposit form (OL4020)

3. Federal/State Tax Withholding

- I am aware that the Federal/State Income Tax Withholding Election form (OL4753) is required to process this request and has been completed and returned with this form.

4. Acknowledgements AND Signatures(s)

I/We understand that unless otherwise requested on this form, withdrawals will be applied proportionately to my current investment options.

I/We am/are aware that there may be tax consequences associated with this transaction. The distribution will be reported to the IRS on Form 1099-R. IRS tax penalties may be assessed for distributions if I/we am/are under age 59-1/2.

I/We understand there may be contractual surrender charges associated with this transaction.

I/We understand that withdrawals from a qualified plan (including section 403(b) contract or Tax-Sheltered Annuity) may be subject to 20% mandatory withholding.

The undersigned requests that the Maturity Date of the above referenced annuity contract be postponed until the maximum maturity date as outlined in the contract.

The undersigned understands that postponing the maturity date does not postpone the distribution of any required minimum distribution amounts that may be required under the Federal Internal Revenue Code. I further understand that any such distributions shall fully be the responsibility of the undersigned, and made by written request.

I/We understand that by processing this request, I am revoking any existing repetitive payment that may be running on my contract.

Under penalties of perjury, I certify that:

- 1) the number shown on this form is my correct Social Security Number or taxpayer identification number, 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 other U.S. person (including a U.S. Resident Alien) as defined in the instructions to the IRS Form W-9, and
- 4) I am exempt from FATCA reporting (if applicable).

Owner Name (Please print)	Telephone Number ()	Owner SSN/TIN
Owner Signature	Date	
Non-Individual Owner Name (Please print) <input type="checkbox"/> Trustee	Trust Tax ID #	
Trustee(s) Signature	Date	
Joint Owner Name (Please print)	Telephone Number ()	Joint Owner SSN/TIN
Joint Owner Signature	Date	



Attached is the form you requested. In order for your request to be processed in a timely manner, the **sections referenced below must be completed on the accompanying form.**

Sections A - D
 All sections **must** be completed in order for the form to be processed. If you are requesting that your payments be deposited to a **checking** account, please be sure to attach a voided check from that account in the area indicated on the form.

Signatures
 Signature requirements are based on the owner designation of the policy/contract. Examples are:

- **Individual:** Print and sign your full name as it appears on the policy/contract.
- **Trust:** The current trustee(s) must sign.
- **Entity:** The current entity must sign.

All signatures must be dated in order to process your request.

Contact Information	US Mail	Shipping / Overnight	Phone	Fax
	PO Box 219361 Kansas City, MO 64121-9361	430 W 7th Street Suite 219631 Kansas City, MO 64105-1407	(800) 541-0171	(816) 221-9674



A. Account Information

Policy/Contract Number	Insured/Annuitant Name(s) (Print full name)
Daytime Telephone Number (include area code)	Mobile Telephone Number (include area code)

B. Deposit Account Please note that we do not accept starter checks.

Attach Voided Check Here

C. Payee Authorization Statement Your bank may take 1-5 business days to reflect the deposit.

I am entitled to receive payments. I hereby authorize the Company to send all payments due to me by Direct Deposit to the account designated above. This authorization shall be effective until further written notice from me is received by the Company and the Company has had reasonable opportunity to act on it. I expressly acknowledge and understand that any Direct Deposit payments made under this agreement will be strictly an accommodation made to me by the Company, that this authorization revokes all prior payment instruction, and that the Company reserves the right to discontinue or decline to honor this agreement at any time.

Recovery Provisions: To correct any overpayments credited to my account during or after my lifetime, I hereby authorize and direct the bank or other depository on my behalf, on behalf of my estate to debit or charge my account and refund such overpayment to the Company. I also agree such payments will be returned to the Company.

D. Consent

By signing, I authorize insurance companies and bank account verification services to provide information to the Company, its affiliates, service providers or its reinsurers. Any information will be used only for the purpose of risk evaluation, validation of bank account ownership or as required by law.

I authorize the preparation of bank account authentication report. I understand that upon request, I am entitled to receive a copy of the bank account authentication report.

This authorization shall continue to be valid for 30 months from the date it is signed unless otherwise required by law. I understand my authorized representative or I may receive a copy of this authorization on request.

Opt Out

I do not consent. I understand that if I do not give my consent, a direct deposit of my surrender proceeds will not be available and instead a check will be mailed to my address on file with the Company.

Signatures

Individually Owned:

Print full name of policy/contract owner(s): _____ SSN: _____

Individual Owner's signature: _____ Date: _____

Joint Owner's signature: _____ Date: _____

Trust Owned:

Print full name of trust including date of trust: _____ TIN: _____

Print full name of trustee(s): _____

Trustee(s) signature: _____ Date: _____

Entity Owned: (corporate resolution required if not on file)

Print full name of Company: _____ TIN: _____

Print full name and title of authorized signor: _____

Authorized signature: _____ Date: _____



Nassau Life and Annuity Company (the Company)
 Nassau Life Insurance Company (the Company)
 PHL Variable Insurance Company (the Company)
Regular Mail: PO Box 219361, Kansas City MO 64121-9361
Overnight Mail: 430 W 7th St., Suite 219361, Kansas City MO 64105-1407

**Federal/State Income Tax
 Withholding Election**

A. Policy/Contract Information

Policy/Contract Number(s)	Insured(s)/Annuitant(s) Names
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B. Federal Income Tax

Complete the following applicable lines. I **elect to withhold** at a flat rate of 10% or _____%.
 I **elect to withhold** at a flat amount of \$ _____.
 I elect **NOT** to have **Federal** income tax withheld.

NOTE: There are penalties for not paying enough income tax during the year, either through withholding or estimated tax payments.

C. State Income Tax

Complete the following applicable lines. I **elect to withhold** at a flat rate of _____%.
 I **elect to withhold** at a flat amount of \$ _____.
 I elect **NOT** to have **State** income tax withheld.

If you reside in one of the following states you must make a state tax withholding election, otherwise we will withhold for state taxes at the rate of 10%:

Arkansas California Connecticut District of Columbia Delaware Georgia Iowa Kansas Massachusetts
 Maine Michigan North Carolina Nebraska Oklahoma Oregon Virginia Vermont

If you reside in one of the following states, we are required to notify you of your right to withhold for state taxes; however, you are not required to make a state tax withholding election. If you do not make an election, we will not withhold for state taxes.

Arizona Indiana Maryland Missouri Montana New Jersey New Mexico
 New York Utah Wisconsin West Virginia

If you do not reside in one of the 28 states listed above, we do not offer state tax withholding. If you make a state tax withholding election and do not reside in one of the listed states, we will not be able to accommodate your request.

D. Taxpayer/Owner Signature

If the Taxpayer is an INDIVIDUAL, complete the following.

Owner Name (Print First, Middle, Last)	Date of Birth (mm/dd/yyyy)	Social Security No./Tax ID	
Street Address (include Apt. or Suite#)	City	State	ZIP Code
Owner Signature			Date (mm/dd/yyyy)

If the Taxpayer is a NON-INDIVIDUAL, complete the following.

Full Name of Trust, Entity, Corporation or Other	Social Security No./Tax ID		
Signing in the capacity as: <input type="checkbox"/> Trustee <input type="checkbox"/> Partner <input type="checkbox"/> Officer _____ <input type="checkbox"/> Other _____ (List corporate title)			
Name (Print First, Middle, Last)	Signature	Date (mm/dd/yyyy)	
Street Address (include Apt. or Suite#)	City	State	ZIP Code
Name (Print First, Middle, Last)	Signature	Date (mm/dd/yyyy)	
Street Address (include Apt. or Suite#)	City	State	ZIP Code