NASSAU RE

Nassau Life and Annuity Company (the Company)
Nassau Life Insurance Company (the Company)
PHL Variable Insurance Company (the Company)
PO Box 219361
Kansas City MO 64121-9361

Guaranteed Lifetime Withdrawal Benefit
Request to Exercise Income Benefit

Contract Number	Contract Owner (Print name)	Joint Owner Name, if applicable

Request to exercise this benefit should be submitted *no earlier than 30 days prior to the earliest exercise date and will be effective on the monthly anniversary following the date the request is received.*

This form is for use in the election of benefits under the Guaranteed Lifetime Withdrawal Benefit. This election determines certain benefits for this rider. See your Rider for further details.

By completing this form, I am electing to exercise my Guaranteed Lifetime Withdrawal Benefit rider. I understand this election will take effect on my next monthly anniversary or after the earliest exercise date as stated in my contract.

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.

1. **Amount of Withdrawal -** Annual Benefit amount only.

☐ Annual Benefit Amount/Benefit Threshold Amount. *(Please Note: In the first year of guaranteed withdrawals, your income payments will be calculated by dividing the annual income amount by the remaining number of modal payments in that contract year. Thus, the payment amounts between rider exercise and your next contract anniversary may be greater than in subsequent years if a monthly payment frequency is chosen.)*

Example: A contract is issued 2/1/2013 and the Guaranteed Lifetime Withdrawal Benefit rider is exercised on 3/1/2013. Assume the Annual Benefit Amount under the rider is $5,000. The monthly payments in the first year will be $5,000 ÷ 11 = $454.55. Starting on the next contract anniversary (2/1/2014), the monthly payments will decrease to $5,000 ÷ 12 = $416.67; however, the total annual amount paid remains the same.

2. **Payment Method/Frequency: (Please select one (1) Method and one (1) Frequency)**

Method: ☐ Direct Deposit (Please return the Direct Deposit form OL4020) ☐ Check mailed to the address of record

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

If no election is made, we will default to monthly.

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

3. **Election of 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, Tax Disclosure and Signature**

- The undersigned requests that the Maturity Date of the above refrenced annuity contract be postponed until the maximum maturity date as outlined in the contract I 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 acknowledge that if distributions are received prior to age 59 1/2, a 10% penalty may be assessed by the IRS.
- I/We understand that exercising the Guaranteed Lifetime Withdrawal Benefit impacts various features of my rider as described by my contract.
- I/We acknowledge that withdrawals over the Annual Benefit Amount/Benefit Threshold Amount: 1) will negatively impact the benefits and guarantees provided by the rider; 2) could terminate the Rider without value and without a refund of charges; and 3) may be subject to a surrender charge and a Market Value Adjustment.
- I/We hereby make this systematic withdrawal request and understand that there may be tax consequences. I/We acknowledge that the Company assumes no responsibility for the legal or tax consequences of this distribution.

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct 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, 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; and
4. FATCA reporting does not apply to me.

5. I/We the Owner, acknowledge that by exercising this rider, I/we agree to the following:

- **The Rider Exercise is irrevocable.**
- **The Rider Exercise Date will be set to the Monthly Anniversary following the date this form is received and processed by the Company.**
- **The Annual Benefit Amount is set on the Rider Exercise Date and will only change in the event of an Excess Withdrawal.**
- **I/We understand that by processing this request, I am revoking any existing repetitive payment that may be running on my contract.**

Owner Name **(Please print)**	Telephone Number ( )	Owner SSN/TIN
Owner Signature		Date
Non-Individual Owner Name **(Please print)** ☐ Trustee		Trust Tax ID #
Trustee(s) Signature		Date
Joint Owner Name **(Please print)**	Telephone Number ( )	Joint Owner SSN/TIN
Joint Owner Signature		Date

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Nassau Life and Annuity Company (the Company)
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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

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: ☐ Trustee ☐ Partner ☐ Officer _____ (List corporate title) ☐ Other _____			
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

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Direct Deposit
Quick Reference

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

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Direct Deposit

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: _____