



Eagle Life Insurance Company®  
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# Beneficiary Claim Form for Non-Qualified Contracts

(Deaths Occurring 01/01/2020 or later)

| SECTION 1: DECEDENT INFORMATION   |                    |   |               |                 |
|---|--------------------|---|---------------|-----------------|
| List Contract Numbers:  |                    | Decedent Name:                                      |               |                 |
|   |                    | <input type="checkbox"/> Death Certificate enclosed |               |                 |
| SECTION 2: BENEFICIARY INFORMATION  |                    |   |               |                 |
| (Prefix)  | Legal Name (First) | (Middle)  | (Last)        | (Suffix)        |
|   |                    |   |               |                 |
| Trust or Entity Name:   |                    |   |               |                 |
|   |                    |   |               |                 |
| SSN/TIN:  |                    | DOB (mm/dd/yyyy):                                   |               | Marital Status: |
|   |                    |   |               |                 |
| Physical Address:   |                    | City:   | State:        | Zip Code:       |
|   |                    |   |               |                 |
| Mailing Address:  |                    | City:   | State:        | Zip Code:       |
|   |                    |   |               |                 |
| Email:  |                    |   | Phone Number: |                 |
|   |                    |   |               |                 |
| SECTION 3: TYPE OF BENEFICIARY - <i>Please Choose One</i>   |                    |   |               |                 |
| <b>Complete the following section to indicate the type of beneficiary you are.</b> It is your responsibility to ensure you select the correct type of beneficiary within the IRS rules. You may want to consult a tax adviser for assistance.   |                    |   |               |                 |
| <input type="checkbox"/> <b>A. DESIGNATED BENEFICIARY</b> (Please also complete section 4)<br><i>If you are an individual select this option.</i>   |                    |   |               |                 |
| <input type="checkbox"/> <b>B. NON-INDIVIDUAL BENEFICIARY</b> (Please also complete section 5)<br><i>If you are an estate, charity, entity or trust select this option.</i>   |                    |   |               |                 |
| SECTION 4: CLAIM OPTIONS - DESIGNATED BENEFICIARY - <i>Please Choose One</i>  |                    |   |               |                 |
| It is your responsibility to ensure that your withdrawals comply with the IRS rules and deadlines. You may want to consult a tax adviser for assistance.  |                    |   |               |                 |
| <input type="checkbox"/> <b>A. SPOUSAL CONTINUATION</b> (Please also complete sections 7, 8, 9 and 11)<br><i>Spouse must be the sole primary beneficiary.</i>   |                    |   |               |                 |
| <input type="checkbox"/> <b>B. INHERITED STRETCH</b> (Please also complete sections 7, 8, 9 and 11)<br><i>Please complete the following:</i><br><b>This <u>must</u> be elected and payments must begin <u>no later than one year from the date of the decedent's death.</u></b><br>I wish to begin receiving the stretch payments as set forth by the Internal Revenue code. Please begin distributions:<br>_____ (Month/Year)<br>I wish to receive my distributions (select one): <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-Annually <input type="checkbox"/> Annually<br><b>If no beginning distribution date is entered below we will default to ANNUAL distributions, starting in the TWELFTH MONTH following the decedent's date of death.</b> |                    |   |               |                 |

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## SECTION 4: CLAIM OPTIONS - DESIGNATED BENEFICIARY *Continued - Please Choose One*

**C. SETTLEMENT OPTION** (Please also complete sections 6, 7, 8, 9 and 11)

*This election is irrevocable.*

**D. 5-YEAR DEFERRAL** (Please also complete sections 7, 8, 9 and 11)

*Proceeds must be completely withdrawn within 5 years. Year 1 begins the date of the decedent's death.*

**E. LUMP-SUM PAYOUT** (Please also complete sections 7, 8 and 11)

## SECTION 5: CLAIM OPTIONS - NON-INDIVIDUAL BENEFICIARY - *Please Choose One*

It is your responsibility to ensure that your withdrawals comply with IRS rules and deadlines. You may want to consult a tax adviser for assistance.

**A. SETTLEMENT OPTION** (Please also complete sections 6, 7, 8, 9 and 11)

*This election is irrevocable, and a 5-year specified period is the only available option.*

**B. 5-YEAR DEFERRAL** (Please also complete sections 7, 8, 9 and 11)

*Proceeds must be completely withdrawn within 5 years. Year 1 begins the date of the decedent's death.*

**C. LUMP-SUM PAYOUT** (Please also complete sections 7, 8 and 11)

## SECTION 6: SELECTION OF SETTLEMENT OPTION BENEFITS (IRREVOCABLE)

Once annuity payments begin, this beneficiary claim option becomes irrevocable.

Installments for Specified Period

**Please note:**

- Designated beneficiaries cannot exceed their life expectancy.
- Non-Individual beneficiaries can only elect a 5 year period.

Death benefit paid in equal installments for duration of the specified period only. Upon your death, any remaining payments will be paid to your beneficiary.

**The specified period shall be \_\_\_\_\_ years. (Minimum 5 years)**

I wish to receive my distributions (select one):     Monthly     Quarterly     Semi-Annually     Annually

First payment to begin \_\_\_\_\_ (Month/Year)

Lifetime Income with  
Installments for Specified Period

**Please note:** Only available to designated beneficiaries.

Death benefit paid for the period of time you specify, and then for as long as you live. Upon your death, any remaining payments in the specified period will be paid to the beneficiary. The specified period cannot exceed your life expectancy.

**The specified period shall be \_\_\_\_\_ years. (Minimum 5 years)**

I wish to receive my distributions (select one):     Monthly     Quarterly     Semi-Annually     Annually

First payment to begin \_\_\_\_\_ (Month/Year)

# Beneficiary Claim Form for Non-Qualified Contracts

## SECTION 7: TAX WITHHOLDING ELECTION

SEE STATE SPECIFIC INSTRUCTIONS ON PAGE 8.

Federal law requires us to withhold 10% of the taxable portion of your distribution for federal income tax. You may elect not to have federal income tax withheld or you may elect a higher withholding rate. Even if you elect not to have federal income tax withheld, you may be responsible for paying estimated taxes. You may incur penalties under the estimated tax rules if your payment of estimated tax and withholding, if any, are not sufficient to satisfy your tax liabilities.

Your distribution may also be subject to state income tax withholding. Some states require that state income tax be withheld when federal income tax is withheld. Additionally, some states have minimum withholding requirements. If you live in one of these states, we will withhold state income tax as required by your state. In other states, withholding is voluntary.

### Federal Withholding Election:

- I do not want federal income tax withheld.
- I do want the following federal income tax withheld: \_\_\_\_\_% federal (minimum withholding is \$10.00.)

### State Withholding Election:

- I do not want state income tax withheld.
- I do want the following state income tax withheld: \_\_\_\_\_% state (minimum withholding is \$10.00.)

In which state do you file your taxes? \_\_\_\_\_

If you do not make a withholding election, or if you do not specify a withholding amount, we will withhold 10% federal income tax and will not withhold any state income tax, unless a different amount is required by your state.

## SECTION 8: SUBSTITUTE IRS FORM W-9

Under penalties of perjury, I certify that:

1. My Social Security number or taxpayer identification number shown on this form is correct;
2. I am not subject to backup withholding due to failure to report interest or dividend income;
3. I am a U.S. citizen or other U.S. person (as defined in the W-9 instructions); and
4. I am not subject to FATCA reporting because I am a U.S. person and the account is located within the United States.

**Certification Instructions: You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest or dividends on your tax return. If you are not a U.S. citizen or other U.S. person for tax purposes, please cross out certifications 3 and 4 and complete and return to us the appropriate IRS documentation.**

Are you a U.S. Citizen (or entity)?

- Yes. No additional information is needed for this section.
- No. Please complete the following (as required by the Internal Revenue Service):
- Cross out lines 3 and 4 above.
  - Individuals: Complete Form W-8BEN (available on the Internal Revenue Service's website), and include the W-8BEN with this form.
  - Entities: Please consult a qualified tax advisor to determine and complete the appropriate W-8 form, and include that with this form.

# Beneficiary Claim Form for Non-Qualified Contracts

## SECTION 9: BENEFICIARY DESIGNATION(S)

Please complete this section *(unless you selected the Lump-Sum Payout)*. Percentages must total 100% per beneficiary type. If you do not designate a beneficiary, upon your death, any undistributed death benefit will be payable to your estate. If you do not provide an email address for a beneficiary, we will assume they do not have an email address.

|   |                    |          |        |                   |          |               |           |
|---|--------------------|----------|--------|-------------------|----------|---------------|-----------|
| <b>Beneficiary</b> <input type="checkbox"/> Primary <input type="checkbox"/> Contingent |                    |          |        |                   | Share %: | Relationship: |           |
| (Prefix)  | Legal Name (First) | (Middle) | (Last) | (Suffix)          |          |               |           |
| Trust or Entity Name:   |                    |          |        |                   |          |               |           |
| SSN/TIN:  |                    |          |        | DOB (mm/dd/yyyy): |          |               |           |
| Mailing Address:  |                    |          |        | City:             |          | State:        | Zip Code: |
| Email:  |                    |          |        | Phone Number:     |          |               |           |
| <b>Beneficiary</b> <input type="checkbox"/> Primary <input type="checkbox"/> Contingent |                    |          |        |                   | Share %: | Relationship: |           |
| (Prefix)  | Legal Name (First) | (Middle) | (Last) | (Suffix)          |          |               |           |
| Trust or Entity Name:   |                    |          |        |                   |          |               |           |
| SSN/TIN:  |                    |          |        | DOB (mm/dd/yyyy): |          |               |           |
| Mailing Address:  |                    |          |        | City:             |          | State:        | Zip Code: |
| Email:  |                    |          |        | Phone Number:     |          |               |           |
| <b>Beneficiary</b> <input type="checkbox"/> Primary <input type="checkbox"/> Contingent |                    |          |        |                   | Share %: | Relationship: |           |
| (Prefix)  | Legal Name (First) | (Middle) | (Last) | (Suffix)          |          |               |           |
| Trust or Entity Name:   |                    |          |        |                   |          |               |           |
| SSN/TIN:  |                    |          |        | DOB (mm/dd/yyyy): |          |               |           |
| Mailing Address:  |                    |          |        | City:             |          | State:        | Zip Code: |
| Email:  |                    |          |        | Phone Number:     |          |               |           |
| <b>Beneficiary</b> <input type="checkbox"/> Primary <input type="checkbox"/> Contingent |                    |          |        |                   | Share %: | Relationship: |           |
| (Prefix)  | Legal Name (First) | (Middle) | (Last) | (Suffix)          |          |               |           |
| Trust or Entity Name:   |                    |          |        |                   |          |               |           |
| SSN/TIN:  |                    |          |        | DOB (mm/dd/yyyy): |          |               |           |
| Mailing Address:  |                    |          |        | City:             |          | State:        | Zip Code: |
| Email:  |                    |          |        | Phone Number:     |          |               |           |

# Beneficiary Claim Form for Non-Qualified Contracts

## SECTION 9: BENEFICIARY DESIGNATION(S) - *Continued*

|                       |                    |  |                   |           |               |
|-----------------------|--------------------|--|-------------------|-----------|---------------|
| <b>Beneficiary</b>    |                    | <input type="checkbox"/> Primary <input type="checkbox"/> Contingent |                   | Share %:  | Relationship: |
| (Prefix)              | Legal Name (First) | (Middle)   | (Last)            | (Suffix)  |               |
| Trust or Entity Name: |                    |  |                   |           |               |
| SSN/TIN:              |                    |  | DOB (mm/dd/yyyy): |           |               |
| Mailing Address:      |                    | City:  | State:            | Zip Code: |               |
| Email:                |                    |  | Phone Number:     |           |               |
| <b>Beneficiary</b>    |                    | <input type="checkbox"/> Primary <input type="checkbox"/> Contingent |                   | Share %:  | Relationship: |
| (Prefix)              | Legal Name (First) | (Middle)   | (Last)            | (Suffix)  |               |
| Trust or Entity Name: |                    |  |                   |           |               |
| SSN/TIN:              |                    |  | DOB (mm/dd/yyyy): |           |               |
| Mailing Address:      |                    | City:  | State:            | Zip Code: |               |
| Email:                |                    |  | Phone Number:     |           |               |

# Beneficiary Claim Form for Non-Qualified Contracts

## SECTION 10: FRAUD WARNING STATEMENTS

**Alabama, Arkansas, Louisiana, New Mexico, Rhode Island, and West Virginia:** 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 any may be subject to restitution, fines, or confinement in prison, or any combination thereof.

**Alaska:** 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.

**Arizona:** 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.

**California:** For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**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 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.

**Delaware, Idaho, Indiana:** 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.

**D.C.: WARNING:** It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

**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.

**Kentucky:** 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.

**Maine, Tennessee, Virginia 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.

**Maryland:** 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.

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

**New Hampshire:** 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 NH Rev. Stat. Ann. §638:20.

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

**Ohio:** 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 a false or deceptive statement is guilty of insurance fraud.

# Beneficiary Claim Form for Non-Qualified Contracts

## SECTION 10: FRAUD WARNING STATEMENTS *Continued*

**Oklahoma:** 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.

**Oregon:** It is fraudulent to fill out this form with information known to be false or omit important facts with the knowing intent to defraud. Criminal and/or civil penalties may result from such acts. An insurer may deny a claim on the basis of misstatements, misrepresentations, omissions, or concealments if such misinformation is material to the contract, the insurer relies on the misinformation, and the information is either material to the risk assumed by the insurer or the misinformation was provided fraudulently. Committing any of these acts may result in prosecution for insurance fraud.

**Pennsylvania:** 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.

**Texas:** 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.

### 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.

## SECTION 11: DECLARATION AND SIGNATURE

By signing below, you:

1. Make claim to the death benefit and declare that you have the authority to claim in the capacity you have indicated;
2. Declare that all answers recorded in this claim form are true and complete;
3. Agree that our furnishing of this claim form and any supplemental forms is not an admission of liability by us; and
4. Indicate you have read the appropriate fraud warning statement for your state.

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

**For New York residents: 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.**

\_\_\_\_\_  
Signature and, if applicable, Title\*

\_\_\_\_\_  
Date

*\*If you are signing on behalf of the individual or entity referenced in Section 2 of this form, please indicate the capacity in which you are signing from the options below:*

*Executor*    *Trustee*    *Conservator*    *Attorney-in-fact*    *Other:* \_\_\_\_\_

### RETURN COMPLETED FORM TO:

Eagle Life Insurance Company®  
P.O. Box 71279  
Des Moines, IA 50325-0279

### OVERNIGHT MAIL ADDRESS:

Eagle Life Insurance Company®  
6000 Westown Pkwy  
West Des Moines, IA 50266-5921

# Beneficiary Claim Form for Non-Qualified Contracts

## STATE SPECIFIC INSTRUCTIONS:

**Arizona residents:** If you want to have Arizona taxes withheld, you must submit Form A-4P.

**Arkansas residents:** We are required to withhold state income tax from the taxable portion of your distribution, unless you elect not to withhold using Form AR4P.

**Connecticut residents:** We are required to withhold state income tax from the taxable portion of your distribution on a full surrender. Connecticut does not allow taxpayers to elect out of withholding on full surrenders. We are required to withhold state income tax from the taxable portion of all other distributions, unless you elect not to withhold using Form CT-W4P.

**District of Columbia residents:** We are required to withhold state income tax from the taxable portion of your distribution on a full surrender from a *qualified* plan (i.e. all contracts other than non-qualified contracts). The District of Columbia does not allow taxpayers to elect out of withholding on full surrenders from *qualified* plans.

**Georgia residents:** If you want to elect not to withhold state income tax, submit Form G-4P.

**Michigan residents:** If you were born after 1945, we are required to withhold state income tax from the taxable portion of your distribution, unless you elect not to withhold using Form MI W-4P.

**New York residents:** If you want to have New York state taxes withheld, submit Form IT-2104-P.

**North Carolina residents:** We are required to withhold state income tax from the taxable portion of your distribution, unless you elect not to withhold using Form NC-4P.

Please consult a tax advisor for more information on withholding requirements for your state.