Physicians Mutual®
Insurance for all of us.™

Physicians Life Insurance Company
Annuity Customer Service
PO Box 2316
Omaha, NE 68172-4081
1.800.720.2891

Annuitization Request for Annuity Contracts

Please mark the appropriate box for each option you are requesting. Please print the requested information. All annuitization proceeds will be mailed to the Annuitant's address of record.

Note: If the Owner is not an individual, additional documentation as to who can sign on behalf of the Owner may be required.

Owner/Annuitant Information

Owner's Name _____

Joint Owner's Name (If applicable) _____

Contract Number _____ Phone Number (____) _____

Fax Number (____) _____ Email Address _____

Annuitant's Name (If different from Owner) _____

Joint Annuitant's Name (If applicable) _____

Distribution Options

I request to distribute the value of the above contract, less any applicable premium tax, under the following annuity income option:

☐ Option One: Life Only
I understand Physicians Life will make payments during the life of the above-referenced Annuitant. I understand and agree payments will cease immediately upon death of the Annuitant and the contract will terminate without further value.

☐ Option Two: Life with Guaranteed Period of _____ years
(Minimum number of years varies by product; refer to your contract for details.)
I understand Physicians Life will make payments for the guaranteed period I have chosen and thereafter for the life of the above-referenced Annuitant. I understand and agree upon the death of the Annuitant, any amount remaining under the guaranteed period selected will be distributed to the Beneficiary named.

☐ Option Three: Income for a Fixed Period of _____ years
(Minimum number of years varies by product; refer to your contract for details.)
I understand Physicians Life will make payments for the fixed period I have chosen. If the Annuitant dies during this period, payments will be made for the remainder of the period to the Beneficiary named.

☐ Option Four: Joint and _____% Survivor Life Income
I understand Physicians Life will make payments during the joint lifetimes of the above-referenced two Annuitants and thereafter during the lifetime of a survivor. I understand and agree the contract ceases without value after the death of both Annuitants.

☐ Lost Contract
I, the undersigned, certify the original contract specified above has been lost, stolen or destroyed. Said contract has not been pledged or assigned. I am the unconditional Owner thereof, and to the best of my knowledge and belief, the original is not being held in the possession of any other person. If at any time the original is found, I will immediately return it to the Company.

Tax Withholding

The Owner is responsible for any tax implications related to these distributions.

Please complete and return form W-4P to elect appropriate Federal Tax Withholding. Your distribution may also be subject to state tax withholding requirements. State withholding requests can be written in on the same form. Your request will not be processed until we receive the Annuitization Request for Annuity Contracts form as well as the completed W-4P form.

Your tax withholding election will remain in effect and apply to all future annuity payments you receive under this contract until you change or revoke it. You may change your withholding election at any time and as often as you wish with regard to future payments in this series by contacting us at 1-800-720-2891 or online at PhysiciansMutual.com to request a new withholding election form.

Annuitant Information (To be completed by Annuitant)

Annuitant's Name _____

Annuitant's Date of Birth (Attach copy of Birth Certificate or Driver's License) _____/_____/_____
Month Day Year

Social Security Number _____–_____–_____

Joint Annuitant's Name _____

Joint Annuitant's Date of Birth (Attach copy of Birth Certificate or Driver's License) _____/_____/_____
Month Day Year

Social Security Number _____–_____–_____

Annuitant Payment Mode

Please make my payments in ☐ Monthly ☐ Quarterly ☐ Semiannual ☐ Annual installments. (It will take approximately 30 days to receive your first annuitization payment after your request has been received at Physicians Life.)

Payment deferral is available up to 12 months. If the statement below is not completed, payments will be effective when the completed Annuitization Request for Annuity Contracts form is received. Deferral is unavailable for Death Claim payouts.

Please defer my payments _____ months.

Annuitant Beneficiary Designation

Primary Beneficiary

Name (Last, First, MI)	Address	Age	Relationship	Social Security Number/ Tax Identification Number	% Allocation

Contingent Beneficiary - If there is no Primary Beneficiary living to receive payment, proceeds will be paid to the Contingent Beneficiary.

Name (Last, First, MI)	Address	Age	Relationship	Social Security Number/ Tax Identification Number	% Allocation

Signatures

It is agreed and understood that:
1. With the election of this distribution option, partial withdrawals and full surrenders are not permitted;
2. The election of this distribution option is IRREVOCABLE;
3. The Owner of the contract is responsible for any taxes resulting from the payout.

X _____ _____
Owner's Signature Date

X _____ _____
Joint Owner's Signature (If applicable) Date

X _____ _____
Annuitant's Signature (If different from Owner) Date

X _____ _____
Joint Annuitant's Signature (If applicable) Date

X _____ _____
Agent's Signature (If applicable) Date

This request will not become effective until approved by the Company in accordance with the terms of the contract. A payment certificate will be sent when the first payment is issued.