ENHANCED INCOME BENEFIT RIDER SERVICE REQUEST FORM

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This form is designed to facilitate the servicing of Fixed Indexed Annuity contracts that have the Enhanced Income Benefit Rider, ensuring EquiTrust has all the necessary details to process your request. To avoid delays, please follow these steps:

1. Availability of benefits varies by state. Please verify benefit eligibility with our Home Office prior to completing this form.
2. Read and sign the Fraud Notice Statement on page 2.
3. Read the Disclosure Statement for the Enhanced Income Benefit Rider on page 3.
4. Complete the Enhanced Income Benefit Rider Service Request Form on page 4. Read this form carefully and sign in the space indicated.
5. Submit the Attending Physician's Statement on page 7 to the physician whose care you are under. The physician should complete the form and return it to you.
6. Read and sign the attached authorization statement on page 8.
7. Return the completed Service Request Form and Attending Physician's Statement to the address listed at the top of this form.

Various jurisdictions impose penalties for misrepresentation of information in order to obtain insurance benefits. Please indicate that you have read the appropriate Fraud Statement by signing your name on the following page.

AK- 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.

AL- 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 and may be subject to restitution fines or confinement in prison, or any combination thereof.

AZ- 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.

AR, DC, LA, RI, and WV- 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.

CA-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."

CO- 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.

DE and ID - 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.

FL- 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.

IN- A person knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

KY- 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.

ME, TN, VA and WA- It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

MD- 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.

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

NH- 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 RSA §638:20.

NJ – Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NM – 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 CIVIL FINES AND CRIMINAL PENALTIES.

OH- 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 false or deceptive statement is guilty of insurance fraud.

PA- 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.

TX - 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.

For All Other States - Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or settlement 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.

_____ _____

Owner Signature Date

_____ _____

Joint Owner Signature Date

DISCLOSURE STATEMENT FOR ENHANCED INCOME BENEFIT RIDER

Eligibility Requirements

This Rider provides for Enhanced Income Withdrawal payments. To activate benefits under this rider, the Eligible Owner must meet all of the following eligibility requirements:

a) This Rider and the Income Benefit Rider is inforce and the Income Benefit Rider is in the Income Period;

b) The Enhanced Waiting Period, as measured from the Enhanced Rider Date, has elapsed;

c) The Accumulation Value of the Contract is greater than zero;

d) The Eligible Owner is able to perform all of the following six Activities of Daily Living (ADLs) on the Enhanced Rider Date: 1) eating; 2) toileting; 3) transferring; 4) bathing; 5) dressing; and 6) continence;

e) A Physician's Statement is provided certifying that the Eligible Owner is Chronically Ill;

f) The Owner(s) is a U.S. resident on the date that benefits under this Rider are requested;

g) No Premiums have been paid into the Contract for at least 2 years prior to the request for benefits under this Rider;

h) On the date that Enhanced Income Withdrawals begin, the age of the Eligible Owner is less than or equal to the Maximum Age for Enhanced Income Withdrawals

Enhanced Income Withdrawals can only be activated one time. To continue Enhanced Income Withdrawals, a Physician's Statement must be provided annually certifying that the Eligible Owner continues to be Chronically Ill. This Rider may terminate if the annual certification requirements are not met. If Enhanced Income Withdrawals are discontinued for any reason, they cannot be started at a later date.

Definitions

Chronically Ill means a person who has been certified by a Physician, during the preceding 12-month period, as: 1) having the permanent inability to perform, without substantial assistance, at least two of six Activities of Daily Living (ADL) for at least 90 days due to a loss of functional capacity; or 2) requiring substantial supervision to protect the individual from threats to health and safety due to permanent severe cognitive impairment.

Eligible Owner means the Contract Owner on whose life the Enhanced Income Withdrawal is based. If Joint Life Income Withdrawals have been elected, the Eligible Owner can be the Owner or the Joint Owner (or the spousal sole primary beneficiary if the Contract is Individually Owned), but not both. Once an Eligible Owner is selected, the Eligible Owner cannot be changed.

Enhanced Income Withdrawal means a Partial Surrender equal to the Enhanced Income Withdrawal Amount.

Enhanced Income Withdrawal Amount means the maximum annual amount that can be withdrawn under this Rider assuming all Eligibility Requirements are met.

Enhanced Waiting Period means the period of time that must elapse before the Eligible Owner can start taking Enhanced Income withdrawals. The Enhanced Waiting Period starts on the Enhanced Rider Date.

Maximum Period for Enhanced Income Withdrawal means the longest period of time for which the Eligible Owner may take Enhanced Income Withdrawals, as measured from the Contract Anniversary immediately preceding the initial request for Enhanced Income Withdrawals.

Physician means a licensed and qualified medical doctor who is not a member of the Owner's or the Joint Owner's immediate family.

ENHANCED INCOME BENEFIT RIDER SERVICE REQUEST FORM

Contract Number	
Owner	Joint Owner
Owner SSN or TIN	Joint Owner SSN or TIN
Contract Owner Telephone No. (REQUIRED)	Contract Joint Owner Telephone No. (REQUIRED)
State(s) in Which Taxes are Filed (Required)	Email Address

1. ENHANCED INCOME WITHDRAWAL REQUEST

We will deduct payments of the Enhanced Income Withdrawal Amount from each crediting account on a pro-rata basis. Enhanced Income Withdrawals must be taken by Electronic Funds Transfer (EFT), unless annual payments are chosen. However, amounts over $50,000 will be distributed via paper check. See the attached Automatic Deposit Authorization Agreement for more information.

Date of First Payment _____

Frequency: ☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually

Income Withdrawals Based On ☐Single Life ☐Joint Lives

Spouse name if Joint Lives elected _____ Spouse's Date of Birth _____

Note: Spouse must be the Joint Owner and/or sole Primary Beneficiary

2. CHRONIC ILLNESS ELIGIBILITY

The Eligible Owner must have been certified by a Physician as Chronically Ill: 1) being unable to perform, without substantial assistance, at least two of the six Activities of Daily Living (ADL) for at least 90 days due to loss of functional capacity; or 2) requiring substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment.

Eligible Owner

Please describe the medical condition contributing to the Eligible Owner's impairments:

3. TAX WITHHOLDING ELECTION

Federal Income Tax Withholding Information:

Federal withholding applies to the taxable portion of any payment made from your annuity. Your withholding rate is determined by the type of payment you receive.

Nonperiodic Payments:

- For nonperiodic payments, the default withholding rate is 10%. You can choose to have a different rate apply by submitting **IRS Form W-4R** (*Withholding Certificate for Nonperiodic Payments and Eligible Rollover Distributions*) and entering a rate between 1% and 100%. You may also choose to not have federal withholding apply.
- For an eligible rollover distribution, the default withholding rate is 20%. You can choose a rate greater than 20% by submitting **IRS Form W-4R**, but you may not choose a rate less than 20%.
- Generally, you can't choose federal withholding less than 10% for payments to be delivered outside the United States and its territories.

(select one option only):

☐ Do not withhold federal income tax from my payment.
☐ Withhold federal income tax at the applicable default rate of 10% or 20% as defined above.
☐ Withhold federal income tax based upon the submitted **Form W-4R.**
☐ Withhold at the rate of _____% or withhold the flat amount of $_____

- You can access **Form W-4R** (*Withholding Certificate for Nonperiodic Payments and Eligible Rollover Distributions*) **here** and on the IRS website at ***IRS.gov***.

NOTE: If you do not make a proper withholding election with your request, we will withhold for federal income tax at the mandatory rate required under law. You may be able to claim a credit for any amounts withheld when you file your tax return with the IRS.

State Income Tax Withholding Information:

If you reside in the US, your state of residence may require or permit us to withhold state income tax. Some states may require you to use specific state forms. If you do not use the proper form or otherwise fail to properly communicate your withholding choice to us, we may withhold in accordance with state default withholding rules. It is your responsibility to determine any applicable state forms that may be required and to provide them to us.

- If your state allows voluntary withholding, you may be able to choose a state withholding rate that differs from the default rate, or you may choose not to have state withholding apply **(select one option only)**:
- No state tax withholding will be taken for states where withholding is not available.
- State specific tax withholding requirements are subject to change at any time. Please consult a tax preparer or your state Department of Revenue for more information.

(select one option only):

☐ Do not withhold state income tax from my payment (if allowed).
☐ Withhold state income tax at the default rate applicable for my state.
☐ Withhold state income tax at _____% (if allowed).
☐ Withhold state income tax for the flat dollar amount of $_____ (if allowed)

Additional Withholding Information:

If you elect not to have withholding apply to your distribution, or if you do not have enough tax withheld, you may be responsible for payment of estimated tax. You may also be subject to tax penalties under the estimated tax rules if your withholding and estimated tax payments are not sufficient. Subject to specific exceptions under the Internal Revenue Code, any taxable distribution from an annuity contract prior to age 59½ may be subject to a 10% excise tax.

4. NOTES

Withdrawals that exceed the Enhanced Income Withdrawal Amount in any Contract Year will reduce the Enhanced Income Withdrawal Amount in future Contract Years. Any unpaid Income payments cannot be added to future Income payments.

Enhanced Income Withdrawals are not subject to a Surrender Charge or Market Value Adjustment. Enhanced Income Withdrawals reduce the penalty free amount available during the current Contract Year.

Additional Premium Payments are not accepted once Enhanced Income Withdrawals begin.

5. REQUEST TO STOP WITHDRAWALS

☐ Stop Enhanced Income Withdrawals effective immediately

☐ Stop Enhanced Income Withdrawals effective _____

I understand that once Enhanced Income Withdrawals are stopped, they cannot be restarted.

6. TERMINATION OF RIDER

☐ I wish to terminate the Enhanced Benefit Rider from my contract effective immediately.

NOTE: Once the rider has been terminated, you may not re-elect it and it cannot be reinstated by the Company. There will be no further payments made from the Rider once it is terminated.

7. CERTIFICATION OF TAXPAYER IDENTIFICATION NUMBER

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct Taxpayer Identification Number (or I am waiting for a number to be issued to me), 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 U.S. resident for tax purposes.

NOTE: The IRS does not require your consent to any provision of this document other than the certification above.

Signatures required on next page

8. SIGNATURES AND AUTHORIZATION

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

I understand that all changes are subject to the terms of any annuity contract/rider and acceptance by the Company and that upon acceptance, changes become party of my annuity contract/rider. I understand the Company and its representatives cannot give legal, tax or accounting advice and that I am solely responsible for all tax obligations arising from this transaction and for compliance with all applicable laws and regulations.

Spouse signature is required where community property laws are applicable. State jurisdictions with community property laws are Alaska, Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington and Wisconsin.

Unless the Insurance Company has been notified of a community or marital property interest in this Contract, the Insurance Company will rely on its good faith belief that no such interest exists and will assume no responsibility for inquiry.

EquiTrust reserves the right to validate client-provided information.

If you are signing on behalf of a policy owner, please include your title when signing.

Owner Signature	Printed Name of Owner	Date
Joint Owner Signature	Printed Name of Joint Owner	Date
Spouse Signature (if required)		Date

Statement of Irrevocable Beneficiary and Assignee (if any)
The undersigned hereby releases all rights, title, interest, and claim in and to any Enhanced Income Benefit Withdrawals from the contract identified above. This release is in all respects absolute and no right, title, interest, or claim, vested or contingent, present or future, is reserved in the contract to the undersigned, or to anyone claiming through the undersigned (including, but not limited to, any Beneficiary designed under this contract), at this or any future time, for the benefits paid under any Enhanced Benefit Payments.

Irrevocable Beneficiary or Assignee Name (Corporate or Individual)	Irrevocable Beneficiary or Assignee Signature
Title, if Assignee	Date

9. ATTENDING PHYSICIAN'S STATEMENT

The patient is responsible for the completion of this form without expense to the Company.

Patient Name	Date of Birth

CHRONIC ILLNESS

The patient must be certified as Chronically Ill, which is being unable to perform at least two of the following activities of daily living for at least 90 days, or requiring substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment.					
Is there Severe Cognitive Impairment? ☐ Yes ☐ No					
Please certify which of the activities of daily living the patient is unable to perform, if any:					
☐ Bathing	☐ Continence	☐ Eating	☐ Dressing	☐ Toileting	☐ Transferring
Date the condition began					

Physician Name	Physician Federal Tax ID
Physician Address	Physician Phone
Physician Signature	Date
Notice: 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 act, which is a crime.	

AUTHORIZATION FOR RELEASE OF INFORMATION

EquiTrust Life Insurance Company ("the Company") or its reinsurers may obtain information about me from: any physician, medical practitioner, hospital, clinic or other medical or medically-related facility, insurance company or other organization, institution or person that has any records or knowledge of my personal history, physical or mental condition. The purpose is to determine eligibility for insurance proceeds. The Company or its reinsurers may obtain personal information and any records available as to diagnosis, care, treatment and prognosis of any physical or mental condition, and may obtain an investigative consumer report.

To facilitate rapid submission of such information, all sources are authorized to give such information or records to any entity designated by the Company or its reinsurers to collect and transmit such information.

This Authorization includes information about mental health care (other than psychotherapy notes), developmental disability care, and drug and alcohol abuse treatment. I understand that: (1) I can revoke this authorization at any time by written notice to the Company; (2) revocation of this authorization will not affect any prior action taken by the Company in reliance upon this authorization; and (3) failure to sign, or revocation of this authorization may impair the Company's ability to evaluate claims and may be a basis for denying a claim for benefits or proceeds.

The company may disclose information to its reinsurers, those who perform services for the Company or its reinsurers, and the Company's affiliates for claims handling, servicing, and other purposes. Disclosure may also be made when required or permitted by law. Some of the health information noted above may be disclosed to persons or organizations that are not subject to federal health information privacy laws, resulting in the information no longer being protected under such laws.

Individuals have the right to see personal information collected about them, and have the right to correct any information that may be wrong. I understand that I may obtain a description of this Company's information practices by requesting one from my agent or the Company at the address provided with my Contract.

This Authorization is valid for one year from the date below. A copy of this Authorization shall be as valid as the original.

I have received a copy of this Authorization.

By signing this form, I represent that the statements and answers given herein are true and complete to the best of my knowledge and belief.

Owner Signature	Date (mm/dd/yyyy)
Joint Owner Signature	Date (mm/dd/yyyy)
Irrevocable Beneficiary/Assignee Signature (If applicable)	Date (mm/dd/yyyy)

AUTHORIZATION FOR RELEASE OF INFORMATION (CLIENT COPY)

EquiTrust Life Insurance Company ("the Company") or its reinsurers may obtain information about me from: any physician, medical practitioner, hospital, clinic or other medical or medically-related facility, insurance company or other organization, institution or person that has any records or knowledge of my personal history, physical or mental condition. The purpose is to determine eligibility for insurance proceeds. The Company or its reinsurers may obtain personal information and any records available as to diagnosis, care, treatment and prognosis of any physical or mental condition, and may obtain an investigative consumer report.

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