LIFE POLICY BENEFICIARY STATEMENT

EquiTrust Life Insurance Company®
7100 Westown Parkway, Suite 200
West Des Moines, Iowa 50266-2521
(866) 598-3692 Fax: (515) 226-5101
www.EquiTrust.com
Mailing Address: PO Box 14500
Des Moines, Iowa 50306-3500

1. LIFE POLICY NUMBERS - One form may be used for multiple Contracts, unless different Payment Options are selected.

List all life Policy number(s) for which you are claiming death benefits:

2. INFORMATION ABOUT THE DECEASED

Decedent's Name			Also Known As (if applicable)
Date of Birth	Date of Death	Country Where Death Occurred	Decedent's Social Security Number

- One copy of a certified death certificate listing the cause of death.
- If death occurred outside the United States, an original U.S. Consular's Report of the Death of an American Citizen is required.

3. BENEFICIARY INFORMATION - In what capacity are you claiming the death benefit? Mark appropriate box.

☐	**Beneficiary (individual)** – Complete one form for each Beneficiary.
☐	**Trustee of living (inter vivos) trust** – Complete the Trust Information/Certification, form ET-Trust-2502. Contact our office to request this form. The tax identification number should be that of the trust.
☐	**Trustee of testamentary trust** – Complete the Trust Information/Certification, form ET-TRUST-2502. Contact our office to request this form. Attach copy of the will and letters of testamentary.
☐	**Executor, administrator or personal representative** – Include court certificate of appointment. Complete the form with the estate information rather than your personal information. The claim is payable to the estate.
☐	**Charity or corporation** – Complete the Entity Certification and Indemnification Agreement, form ET-ENTITY-2503 and any other required supporting documents. Contact our office to request this form.
☐	**On behalf of a minor child as attorney-in-fact or as conservator or guardian** – Include appropriate documentation. Tax identification should be that of the minor child.
☐	**Foreign Beneficiary** – Natural person: include a completed and signed IRS Form W-8BEN.
☐	**Assignee –** Your official title is _____
☐	**Power of Attorney -** a copy of the POA document and POA Certification, form E-POACERT-2500 if POA document is over 1 year old.
☐	**Spouse of decedent**
☐	**Other**: _____ _____

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4. BENEFICIARY CONTACT INFORMATION

Beneficiary Name/Name of Estate/Charity/Corporation		Also Known As (if applicable)	
Date of Birth (mm/dd/yy)	Social Security / Tax Identification No. (TIN)	Beneficiary Telephone No. (REQUIRED)	
Street Address	City	State	Zip Code
Mailing Address (if different than above)	City	State	Zip Code
Email Address	Relationship to Deceased		

5. PAYMENT OPTIONS - If your share of proceeds is ***more than $2,000***, you may choose a payment option or a lump sum settlement. If it is less than $2,000 the proceeds **must** be paid in a lump sum.

☐ **Share of Proceeds less than $2,000**
If your share of proceeds is less than $2,000 your option is a lump sum and this will be paid to you by check.

Note: Electronic Funds Transfer (EFT) is not available for Lump Sum payments.

☐ **Share of Proceeds more than $2,000**
If your share of proceeds is more than $2,000 your options are:

☐ **Payment Option** – if elected the Beneficiary Payment Option Election Form ETL-BENPOE-2710 must also be completed.

☐ **Lump Sum Settlement**

Note: Electronic Funds Transfer (EFT) is not available for Lump Sum payments.

6. FOREIGN BENEFICIARY

Beneficiary is NOT a United States citizen (Foreign Beneficiary) – If the Beneficiary is not a United States Citizen, the Company is required to withhold up to 30% of any gain and/or interest from the benefit payable to the Beneficiary. A special withholding rule exists if the Beneficiary is a citizen of, and resides in, a country with which the United States has an income tax treaty. A list of treaty countries provided in IRS Publication 901 (United States Tax Treaties) which can be obtained from the IRS website at www.IRS.gov or from an IRS office in the Beneficiary's country of residence. In order for the Company to institute a lower treaty rate, the Beneficiary's United States Taxpayer Identification Number (TIN) must be provided.

- If the Beneficiary does not have a United States TIN, one can be obtained from the Internal Revenue Service by using IRS Form W-7 (Application for IRS Individual Taxpayer Identification Number).
  NOTE: The Company does not facilitate the Beneficiary's application for a TIN. Please do not return IRS Form W-7 to our office.
- If all other documents necessary to settle the claim(s) have been provided, the Company will proceed with settlement of the claim and withhold 30% of the gain and/or interest.
- **Foreign Beneficiary (Natural Person):** A completed and signed IRS Form W-8BEN, (Certificate of Foreign Status of a Beneficial Owner for United States Tax Withholding) must be provided.
- **Foreign Beneficiary (Entity):** The claim form must be signed by an authorized representative of the organization. A copy of the corporate resolution, bylaws or other documents verifying that signer(s) of the claim form are authorized to act on behalf of the organization must be provided.
  A completed and signed IRS Form W-8-IMY (Certificate of Foreign Intermediary, Foreign-Through Entity, or Certain U.S. Branches for United States Tax Withholding) must be provided.

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.

8. NEW YORK NOTICE

Residents of NY: 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.

9. ILLINOIS NOTICE

If the policy was issued in Illinois: interest shall accrue on the proceeds payable because of the death of the insured, from date of death, at the rate of 10% on the total amount payable or the face amount if payments are to be made in installments until the total payment or first installment is paid, unless payment is made within thirty-one (31) days from the latest of the following to occur: 1) date due proof of death is received by the company; 2) date the company receives sufficient information to determine its liability, the extent of the liability and appropriate payee entitled to proceeds; or 3) date the legal impediments to payment of proceeds that depend on others outside the company are resolved and sufficient evidence of the same is provided to the company.

10. LOST POLICY

☐ I certify that this Policy has been lost or destroyed and that it was not assigned, hypothecated, or pledged in any way whatsoever. I agree that should the original Policy be found or in any way come into my possession, it will immediately be returned to EquiTrust. It is expressly understood that after payment of death benefit, the original Policy shall become null and void. I agree to indemnify EquiTrust against any loss that may be sustained as a result of having paid this claim.

Signatures required on the next page

11. REQUIRED SIGNATURES – BENEFICIARIES

As the Beneficiary, trustee(s), executor(s), legal guardian, custodian, attorney-in-fact, or signing officer, please sign your name and date below. **If you do not sign and date below, processing of your claim will be delayed.**

By signing below, you are confirming that you have reviewed the applicable state fraud notice at the end of the form.

- If signing on behalf of a Trust you must complete the Trust Information/Certification, form ET-TRUST-2502
- If a Trust and the named trustee is a company/corporation, the person(s) signing below on behalf of the corporate trustee are duly authorized by the company/corporation to do so.
- 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.

Signature	Title (if Trust or Corporation)	Date (mm/dd/yy)
Signature	Title (if Trust or Corporation)	Date (mm/dd/yy)

If you are signing on behalf of the Beneficiary, check one of the boxes to indicate the capacity in which you are signing and provide documentation to verify your authorization to act on behalf of the Beneficiary.
SIGNATURE MUST BE NOTARIZED.

☐ Conservator ☐ Guardian ☐ Power of Attorney ☐ Executor

Signature	Name (please print)	Date (mm/dd/yy)

Street Address	City	State	Zip	Phone Number

Notary Signature Section

State of _____

County of _____

On this ____ day of _____, 20____, before me, the undersigned, a Notary Public in and for the State of _____, personally appeared _____, to me known to be the person named in and who executed the foregoing Certification, and acknowledged that he/she executed the same as his/her voluntary act and deed.

_____
Notary Public* Signature

*Note: Per EquiTrust Life Insurance Company Business Guidelines, agents may not act as notary on client's financial transactions.

(Affix Notary's Stamp or Seal Here)

My commission expires_____

EquiTrust® Life Insurance Company

FRAUD NOTICES

EquiTrust Life Insurance Company®
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Important: This is part of the Annuity Claim Form. Please review the applicable fraud notice for your State below.

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 you 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.

FRAUD NOTICES CONTINUE ON THE NEXT PAGE

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.

OK – 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.

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.

BENEFICIARY PAYMENT OPTION ELECTION

EquiTrust Life Insurance Company®
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1. BENEFICIARY INFORMATION – Please print

Beneficiary Name	Beneficiary Telephone No. (REQUIRED)
Payment Election for Policy Number	
Preferred Payment Date	

NOTE: The selected Payment Date reflects the date on which payments are processed at our offices. The date of payment delivery or deposit to your account may be delayed due to mailing time or bank processing time, depending on the selected delivery method.

2. PAYMENT OPTION ELECTION – Complete one from A or B below

A. Fixed Period Only (Select one): ☐ 5 years* ☐ 10 years ☐ 15 years ☐ 20 years ☐ 30 years

☐ Other _____Whole years only. Fixed Period cannot be less than 5 years or greater than 30 years.

B. Life Income (Select one):

☐ Life Only
_____I understand that in the event of my death, no further payments will be made.
(Initials)

☐ Life with Fixed Period ☐ 5 years* ☐ 10 years ☐ 15 years ☐ 20 years

☐ Other _____Whole years only. Fixed Period cannot be less than 5 years or greater than 20 years.

*Not all payment options may be available in all states or with all products.

Payment Frequency ☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually

Note: If any option other than Annually is chosen, Electronic Funds Transfer (EFT) is required. Please complete the attached Automatic Deposit Authorization Agreement.

3. DESIGNATION OF BENEFICIARIES – Indicate primary and secondary beneficiaries who would receive benefits if you die and benefits remain to be paid. All information must be provided.

Primary Contingent Beneficiaries

Name	Address and Telephone Number (REQUIRED)	Date of Birth	Social Security Number	Is this person a U.S. citizen?	If "No" is this person a Resident Alien?	Relationship to Owner	Percent

Attach a second form if you wish to designate additional Primary Contingent Beneficiaries.
The Primary Contingent Beneficiaries named above who survive you shall share equally unless otherwise indicated.

EquiTrust Life Insurance Company

Secondary Contingent Beneficiaries							
Name	Address and Telephone Number (REQUIRED)	Date of Birth	Social Security Number	Is this person a U.S. citizen?	If "No" is this person a Resident Alien?	Relationship to Owner	Percent

Attach a second form if you wish to designate additional Secondary Contingent Beneficiaries.
The Secondary Contingent Beneficiaries named above who survive you and the Primary Contingent Beneficiaries shall share equally unless otherwise indicated.

4. SIGNATURES

Beneficiary Signature	Date
Social Security Number	

EquiTrust Life Insurance Company

PRIVACY NOTICE

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This notice is required by law. It explains our information practices. Our practices apply to all current, former and future customers.

Information We Collect: In order to help us serve your financial needs and to comply with legal and regulatory requirements, we collect certain information about you. This information varies depending on the products or services you request, but may include:

- Information we receive from you on your application or other forms (such as name, address, social security number and financial and health information), including information you provide via the Internet by completing on-line forms;
- Information you allow us to collect (such as health information for underwriting purposes) or information we are authorized or required by law to collect (such as your taxpayer ID number);
- Information about your transactions with us, our affiliates, or others (such as your payment history or account balances);
- Information we receive from a consumer reporting agency (such as an investigative consumer report, including credit relationships and history); and
- Information we receive from public records (such as your driving record).

Personal information that has been collected about you may be retained both in our records and in your agent's files. Reports prepared by an insurance-support organization may be retained by the insurance support organization and disclosed to other persons.

To the extent provided by law, you have the right to access and correct the information we have collected about you. You are also entitled to certain information regarding disclosures of medical information we may have made. To exercise these rights, provide a written request to the address below, which includes your complete name, address, date of birth, type(s) of policy(ies) held or applied for and all policy numbers issued to you by us.

The Security of Your Information: We maintain physical, electronic, and procedural safeguards that comply with state and federal regulations to guard your personal information. Our internal procedures limit access to customer information, and those individuals permitted access are required to protect customer information and to keep it confidential.

Information We Share: We may share your information with our affiliates to assist us in providing service for your products or account. This may include sharing information with our affiliates about your account history or experience with us; however, our affiliates do not use such information for marketing purposes.

We may also share some of the information we obtain about you with certain business partners, such as:

- Sharing information with companies that service your accounts, or that perform services on our behalf,
- Sharing information with companies with whom we have a joint marketing agreement. A joint marketing agreement is one where another financial institution offers a product or service jointly with us.

We require our business partners to protect customers' personal information and to limit their use of information shared to the purpose for which it was shared.

We may also disclose information to non-affiliated third parties as permitted or required by law, including in response to a subpoena, to prevent fraud, to comply with inquiries from government agencies or other regulators, or in order to process a transaction you request or authorize.

We do not share medical information except when needed to service your policies, accounts, claims or contracts; when laws protecting your privacy permit it, or when you consent. Medical information and information obtained from a consumer reporting agency or motor vehicle reports is not used for marketing purposes.

This notice is being provided on behalf of EquiTrust Life Insurance Company.
Receipt of this notice does not mean your application has been accepted. We may change our privacy practices at times. We will give you a revised notice when required by law.

EquiTrust® Life Insurance Company

AUTOMATIC DEPOSIT AUTHORIZATION AGREEMENT

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NOTE: Only one bank account may be on file per client. If automatic deposit is already established, use this form only to revise or update bank account information.

1. OWNER INFORMATION – Please print

Contract/Policy Number	
Owner	Joint Owner (if any)
Owner Social Security Number	Joint Owner Social Security Number
Owner Telephone No. (REQUIRED)	Joint Owner Telephone No. (REQUIRED)
Email Address	State(s) in Which Taxes are Filed (REQUIRED)

AGREEMENT

I hereby authorize EquiTrust to make direct deposits to my account and for the bank named below to accept these deposits. I also authorize EquiTrust to make withdrawals from this account if a credit entry is made in error.

This authority is to remain in force until EquiTrust has written notification from me of its termination in such time and in such manner as to afford EquiTrust a reasonable opportunity to act on it.

2. BANK ACCOUNT INFORMATION

Name of Bank Account Owner (as it appears on the account)		**Name of Joint Bank Account Owner (as it appears on the account)**	
Account Type ☐ **Checking** ☐ **Savings** **Must be a checking or savings account. Money Market or Brokerage accounts are not accepted.**			
Bank Name			
Street Address		**City** / **State** / **Zip**	
Bank Routing Number (9 digits)		**Bank Account Number**	
SIGNATURE(S) (REQUIRED)			
Bank Account Owner Signature	**Date**	**Joint Bank Account Owner Signature**	**Date**
EquiTrust Owner Signature		**EquiTrust Joint Owner Signature**	

IMPORTANT NOTES

- **Distributions greater than $50,000 will be distributed via check.**
- **The electronic transfer of funds may take 2-3 business days to reach your account once funds are released from our office and is subject to your bank processing time.**
- **Lump Sum death claim elections are not eligible for automatic deposits.**

EquiTrust Life Insurance Company