



For NEW ERA LIFE INSURANCE COMPANY
 New Era PHILADELPHIA AMERICAN LIFE INSURANCE COMPANY
 Company: NEW ERA LIFE INSURANCE COMPANY OF THE MIDWEST

DISTRIBUTION REQUEST

P. O. Box 4884 • Houston, TX 77210-4884
 11720 Katy Freeway, Suite 1700 • Houston, TX 77079
 281-368-7200 • 800-713-4680 • Fax: 281-368-7144 • www.NewEraLife.com

PLEASE PRINT OR TYPE

BOTH PAGES OF THIS FORM MUST BE COMPLETED

_____ Annuitant Name(s)	
_____ Owner Name(s)	_____ Policy Number

NOTE: All systematic periodic payments are processed on the 1st of each month. Minimum periodic payment amount is \$125.

PARTIAL WITHDRAWAL

<input type="checkbox"/> I wish to withdraw the maximum free amount from my annuity contract. <input type="checkbox"/> I wish to withdraw \$ _____ from my annuity contract. <input type="checkbox"/> Gross or <input type="checkbox"/> Net <input type="checkbox"/> I wish to start a periodic payment beginning on (MM/YYYY) _____ <input type="checkbox"/> Interest or <input type="checkbox"/> Specific amount of \$ _____ Mode of payment: <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Annual <input type="checkbox"/> I am aware that there may be an early withdrawal charge.

REQUIRED MINIMUM DISTRIBUTION from a Qualified Account

If beneficiary is a spouse who is more than 10 years younger, please indicate date of birth: _____ Do you want automatic distribution? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, indicate start date (MM/YYYY) _____ Mode of payment: <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Annual
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SURRENDER

<input type="checkbox"/> I wish to surrender the policy for its Cash Surrender Value and am aware of any early surrender charges. Please Process: <input type="checkbox"/> Immediately <input type="checkbox"/> On or After _____ The policy is: <input type="checkbox"/> Enclosed <input type="checkbox"/> Lost/Destroyed - I hereby declare under penalty of perjury that the above numbered policy has been lost or destroyed; that it has not been delivered to any person having any right, title or interest in it.

SEND FUNDS TO:

<input type="checkbox"/> Policy Owner's Mail Address <input type="checkbox"/> Direct Deposit to Depository Shown Below

SPECIAL INSTRUCTIONS:

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AUTHORIZATION FOR DIRECT DEPOSIT

I/we hereby authorize the New Era Company checked at the top of this form, hereinafter called the Company, to initiate credit and/or debit entries as adjustments for any credit entries made in error, to the account number shown below.

The depository named below, hereinafter called Depository, is hereby authorized to credit and/or debit the same to such account as indicated. This agreement will remain in effect until the Company terminates it or until a written notice is received from me/us of its termination and the Company has sufficient time to act upon it. If, at any time my/our Depository changes, I/we will provide a new Authorization for Direct Deposit.

Depository Name and Branch	Account Number
Mail Address of Depository – City, State & Zip Code	Transit/ABA Number
Policy Owner Name	Joint Owner Name
Policy Owner Signature	Joint Owner Signature

Please Attach a Blank Voided Check

ELECTION FOR WITHHOLDING (Substitute W4P Form)

Federal and some State laws make payments subject to withholding. The law requires that you be told three things:

1. You do not have to have any money withheld from your periodic payments.
2. After you have made a choice you can change it at any time by writing to us. Please allow 30 days for the change.
3. Even if you elect not to have income tax withheld, you are liable for payment of income tax on the taxable portion of your distribution. You also may be subject to tax penalties under the estimated tax payment rules if your payments of estimated tax and withholding, if any, are not adequate.

CHECK FEDERAL AND/OR STATE (if applicable)

IF NOT CHECKED AND THE PAYMENT AMOUNT IS SUFFICIENT, WE ARE REQUIRED TO WITHHOLD INCOME TAX

FEDERAL:

WITHHOLD

- 10% of taxable portion
- 20% of taxable portion
- Other (specify) _____

DO NOT WITHHOLD

federal income tax from my distribution

STATE: _____

WITHHOLD

- % of taxable portion (specify) _____
- \$ of taxable portion (specify) _____

DO NOT WITHHOLD

state income tax from my distribution

WE ARE REQUIRED TO WITHHOLD IF YOUR RESIDENT ADDRESS IS OUTSIDE OF THE UNITED STATES

SUBSTITUTE W-9 VERIFICATION (Box must be marked to qualify as a substitute W-9)

Please consider this my substitute W-9. If you fail to furnish your correct TIN (taxpayer identification number), you may be subject to a \$50 penalty imposed by the Internal Revenue Service. In addition, in the event of such failure, 31% of your taxable distribution will be withheld and sent to the IRS.

Please enter SSN/TIN of **Policy Owner(s)**: _____

Certification – Under penalties of perjury, I certify by signing below that:



- 1) The number shown above is my correct taxpayer identification number;
- 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 IRS that I am subject to backup withholding as a result of 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. person (including a U.S. resident alien).

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've failed to report all interest and dividends on your tax return.

IMPORTANT TAX INFORMATION

Receipt of any funds from your annuity contract, if from a partial withdrawal or a surrender of the contract, may generate taxable income. In addition, if you are not 59½ years of age or permanently disabled, receipt of funds may be a premature distribution, generating an additional income tax. We suggest you contact your tax advisor before completing this request.

SIGNATURE BLOCK - I (We) certify, under penalties of perjury, that the information reported herein is correct.

_____	
Date	Signature of Policy Owner
_____	
X Witness/Agent	Signature of Joint Owner
_____ Policy Owner's Mail Address – City – State – Zip Code	
_____ Policy Owner's Home Phone – Work Phone – Fax Line – Email Address	