RELIANCE STANDARD
LIFE INSURANCE COMPANY
A MEMBER OF THE TOKIO MARINE GROUP

2001 Market Street, Suite 1500
Philadelphia, PA 19103
(800) 351-7500
Fax to: Annuity Administration, Fax #: 267-256-4713

MINIMUM REQUIRED DISTRIBUTION WITHDRAWAL REQUEST

CONTRACT INFORMATION

Owner Name: _____ Date of Birth: _____ SSN: _____

Policy Number(s): _____

Previous Year-End Contract Value*: _____
*The contract value must be provided only if Reliance Standard did not hold the contract on December 31st of the previous year.

DISTRIBUTION ELECTION (Elect One)

☐ A. Enroll me in the automatic Required Minimum Distribution program for the current tax year and all future tax years.

☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually (Date of Payment: _____)

☐ B. Lump Sum Distribution – I will notify Reliance Standard Life Insurance Company each year if a Required Minimum Distribution should be processed (elect 1. or 2. below)

☐ 1. Calculate and Distribute the Required Minimum Distribution for the current year

☐ 2. I request Reliance Standard Life distribute $ _____ for the current year

☐ C. I have satisfied my Required Minimum Distribution from other qualified accounts for the current tax year. I will notify Reliance Standard Life if a Required Minimum Distribution should be processed in the future.

SIGNATURES

Payments shall reduce the annuity account balance by the amount distributed. Withdrawals in excess of these payments may be made only if the Contract has remaining value, and such withdrawals are subject to surrender charges (and the market value adjustment, if applicable). I hereby certify that I am the proper party to receive payments from this Contract and that all information provided by me is true and accurate. I further certify that no tax advice has been given to me by Reliance Standard Life Insurance Company. All decisions regarding this withdrawal request are my own. I assume the responsibility for any consequences which may arise from these withdrawals and agree that Reliance Standard Life Insurance Company shall in no way be held responsible.

_____ _____
Date Policy Owner's Signature

_____ _____
Witness Irrevocable Beneficiary's Signature (if Applicable)

ELECTION OF WITHHOLDING

You must indicate if Federal/State income tax should be withheld from your payment by signing and dating this election form and returning it to our Home Office. State taxes will be withheld only if required by your state. Even if you elect not to have Federal/State income tax withheld, you are liable for Federal/State income tax on the taxable portion of your payments. You may also be subject to tax penalties under the Estimated Tax Payment rules if your payment of estimated tax and withholding, if any are inadequate. If you have any questions about your tax liability, please contact your tax advisor.

☐ I **do not** want Federal/State income tax withheld from my payment
☐ I **do** want Federal (_____%) / State (_____%) income tax withheld from my payment

X_____
Policy Owner's Signature Social Security Number Date