LIFE CLAIMANT STATEMENT

Jackson National Life Insurance Company

Mailing Address
P.O. BOX 1600
Jacksonville IL 62651-1600

INSTRUCTIONS

The following items are required for all claims:

- An original **certified Death Certificate** showing the cause and/or manner of death.
- The original contract. If unavailable, include an explanation in Decedent Information section of this form.
- **A separate claim form must be completed and signed by each Claimant.**

If the policy has been in force for less than two years during the lifetime of the Insured or if the policy has been reinstated within two years of the Insured's death, then we may perform a routine inquiry into the answers on the application for the policy or reinstatement application of the lapsed policy.

The following special Instructions and additional requirements may apply:

- **If the Claimant is the Estate of the Insured**, we require evidence of the court appointed legal representative over the Estate. Enter "Estate of (Deceased Name)" when completing the Claimant Information and provide the Tax ID Number of the Estate.

- **If the Claimant is a Trust**, we require a Certification of Trust OR a copy of the Trust Agreement and any amendments, including the signature page(s). Enter the Trust's name when completing the Claimant Information and provide the Tax ID Number for the Trust. **Also Complete the Trustee Certification section of the form.**

- **If the Claimant is a corporation,** a Senior Officer must sign on behalf of the corporation, indicating their corporate title. **Supporting documentation dated within the last two years is required indicating the officer is authorized to sign on behalf of the corporation.**

- **If the Claimant is a minor**, we will require evidence of the court appointed guardianship of the Minor's Estate.

- **If the Claimant is an ex-spouse**, we require a copy of the Divorce Decree and Property Settlement Agreement.

- **If the contract is collaterally assigned**, we require a letter from the collateral Assignee stating the balance due under the collateral assignment. **If the collateral Assignee is a corporation, supporting documentation dated within the last two years is required indicating the officer is authorized to sign on behalf of the corporation**.

- **If any beneficiary(ies) is (are) deceased**, we require a Death Certificate for each deceased beneficiary.

- **If the contract has a split dollar agreement associated with it**, we require a copy of said agreement.

- **If death occurred outside of the United States,** we may request additional information or documentation.

- **If the policy is subject to a Viatical or a Life Settlement transaction**, and if the Claimant is a viatical settlement provider, life settlement provider, the receiver or conservator of viatical or life settlement company, a viatical or life financing entity, trustee, agent, securities intermediary or other representative of a viatical or life settlement provider or an individual or entity which invested in this policy as a viatical or life settlement, please complete the relevant questions.

Other requirements may be needed depending on the individual facts of the claim. The company will notify you if other documentation is required.

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FRAUD INFORMATION

For Residents of Alaska, Arizona, Nebraska, New Hampshire and Oregon: 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 may be guilty of a crime and may be subject to fines and confinement in prison.

For Residents of California: For your protection California law requires the following notice 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.

For Residents of Colorado: 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.

For Residents of Florida: 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.

For Residents of Kentucky, Ohio and Pennsylvania: Any person who knowingly & 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 & subjects such person to criminal and civil penalties.

For Residents of Maine, Tennessee and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

For Residents of Maryland: 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.

For Residents of Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

For Residents of New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

For Residents of New Mexico: 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.

For Residents of New York: Please see the Signature section of this form.

For Residents of Puerto Rico: Any person who, knowingly and with intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

For Residents of All Other States: 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.

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DECEDENT INFORMATION

Name of Deceased (Last, First, Middle)	Last 4 digits of Deceased's Social Security No:
If the Deceased was known by any other names, such as maiden name, hyphenated name, nickname, derivative form of first and/or middle name or an alias, please provide them below.	
Policy Number(s)	If policy is lost or not available, please explain:
Deceased's Date of Death	Deceased's Marital Status: ☐ Single ☐ Divorced ☐ Married ☐ Widowed

CLAIMANT INFORMATION

Claimant Name (Last, First, Middle). If Trust, enter Trust name, if Estate enter Estate of (name), and if corporation enter corporation name.

Physical Address (No P.O. Boxes)	City	State	Zip
Mailing Address (May include P.O. Boxes)	City	State	Zip

Date of Birth/Trust	Social Security or Tax ID Number	Relationship to Deceased

Are you a U.S. Citizen? ☐ Yes ☐ No If "No" please list country of citizenship:	Daytime Phone Number:

Policies subject to Viatical / Life Settlement transactions - Are you a viatical settlement provider, life settlement provider, the receiver or conservator of viatical or life settlement company, a viatical or life financing entity, trustee, agent, securities intermediary, or other representative of a viatical or life settlement provider; or an individual or entity which invested in this policy as a viatical or life settlement?	☐ Yes ☐ No

SETTLEMENT OPTIONS – If none elected payment will be made in a lump sum

The policy may contain one or more settlement options. You may choose a settlement option only if available in the policy. **Carefully review your options as elections are irrevocable.**

☐ **I elect to receive a lump sum distribution.** Please send me a check for my proceeds.

I understand that Proceeds Held at Interest will be credited at the rate of interest stated in the policy under the Proceeds at Interest settlement option. A Supplemental Contract will be issued to me for the maximum length of time allowed under the option or my life expectancy, whichever is less.

☐ **Proceeds Held at Interest, Withdrawals Allowed**.** I elect for my proceeds to be held to earn interest for the maximum number of years allowed. I understand that withdrawals without any penalty are allowed at any time.

☐ I would like to take a partial withdrawal now in the amount of $_____ before the Supplemental Contract is set up.

If you wish to select a different settlement option**, indicate your selection by name (not by number) on the line below.

_____

Name of Settlement Option from Policy

****Proof of age required: copy of Birth Certificate, Driver's License or Federal ID Card. Proof is also required for Joint Payees. Benefits commence upon receipt of all requirements in good order.**

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Important Information About the USA PATRIOT Act

To help fight the funding of terrorism and money-laundering activities, the U.S. government has passed the USA PATRIOT Act, which requires banks, including our processing agent bank, to obtain, verify and record information that identifies persons who engage in certain transactions with or through a bank. This means that we will need to verify the name, residential or street address (no P.O. Boxes), date of birth and social security number or other tax identification number of all account owners.

SUBSTITUTE IRS FORM W-9

Under penalty of perjury, I certify that:
1) The tax ID number shown on this form is my correct Taxpayer Identification Number,
2) I am not subject to backup withholding,
3) I am a U.S. citizen or other U.S. person (including a U.S. resident alien),
4) I am exempt from Foreign Account Tax Compliance Act (FATCA) reporting.

Cross through item 2 if you have been notified by the IRS that you are subject to backup withholding because you have failed to report all interest and dividends on your tax return. Cross through item 3 if you are not a U.S. person (including a U.S. resident alien) and complete and return to us the applicable IRS Form W-8BEN to certify your foreign status, and if applicable, claim treaty benefits. Otherwise, we will withhold 30% foreign taxes.

For contracts issued in and residents of Illinois only:

If the policy was issued in Illinois or the Insured or Claimant were a resident of Illinois on the date of death, a valid claim will include interest due and payable from the date of death at a rate of 10% if we do not pay the claim within 31 days from the latest of 1) the date that we receive proof of death, 2) the date we receive sufficient information to determine our liability and the appropriate beneficiary(ies) entitled to the proceeds; or 3) the date that any legal impediments are resolved.

SIGNATURES

I hereby make claim to my share of the death proceeds of the above life insurance policy as Claimant, declare that the answers recorded above are complete and true, and agree that the furnishing of this and any supplemental forms do not constitute an admission by the Company that there was any life insurance in force on the life in question, nor shall it constitute or be considered a waiver of any of the Company's rights or defenses.

For Residents of New York: 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.

For Residents of All Other States: See the Fraud Information section of this claim form.

Signature of Claimant and Title	Date

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TRUSTEE CERTIFICATION (to be completed ONLY if Trust is claiming proceeds)	
Name of Trust	Date of Trust Agreement
Date(s) of All Amendments	Trust Tax ID Number

IMPORTANT – You must include a current/valid Certification of Trust OR a copy of the Trust Agreement, including the signature page(s) and any amendments. The copy provided must be a true and exact copy of the agreement that is in full force and effect.

ELECTION TO USE SURVIVING SPOUSE SSN FOR TRUST

COMPLETION REQUIRED – Select Yes or No boxes below

Beneficial Owner: *A Beneficial Owner is the individual(s) who has personal use of Trust funds during their lifetime (not administrative use, such as a Trustee). We recommend that you consult your tax advisor to be sure that the person(s) you indicate on this form qualify as Beneficial Owner(s).*

☐ Yes, the sole Beneficial Owner of the beneficiary Trust is the surviving spouse of the Deceased Insured and the Trust does not have an EIN/TIN assigned by the IRS and has always used the SSN of the Deceased. We elect to use the surviving spouse's individual SSN for all tax reporting purposes relative to the proceeds payable under this Policy. The Surviving Spouse information is provided as follows:

_____

Printed Full Name Surviving Spouse (Sole Beneficial Owner) | Date of Birth | Social Security Number

☐ No, the sole Beneficial Owner is not the surviving spouse or there are multiple Beneficial Owners. The Trust EIN/TIN will be used for all tax reporting purposes relative to the proceeds payable under this Policy

BENEFICIAL OWNER INFORMATION

Provide the names of the Beneficial Owner(s) of the Trust immediately prior to the death of the Insured:

_____
Printed Full Name of Beneficial Owner | Date of Birth

_____
Printed Full Name of Beneficial Owner | Date of Birth

_____
Printed Full Name of Beneficial Owner | Date of Birth

_____
Printed Full Name of Beneficial Owner | Date of Birth

TRUSTEE SIGNATURE(S) - MUST BE COMPLETED FOR PAYMENT

I/We, the undersigned Trustee(s), represent and warrant that the answers recorded above, and documents provided are complete and true and that I/we have the authority to make this certification.

Printed Name of Trustee(s)	**Signature of Trustee(s)**
a_____	_____
b_____	_____
c_____	_____
d_____	_____

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