Global Atlantic FINANCIAL GROUP

Request For Withdrawal
Terminal Illness Fee Waiver Rider
Forethought Life Insurance Company

Use this form if would want to request a withdrawal under the Terminal Illness Waiver Rider of your contract. Refer to your contract for additional information regarding the amount available to you under the waiver rider. Please section D and E when meeting with your physician.

Section A: Owner Information

Please provide all information requested in this section. It is important that you provide your telephone number in the event we require additional information to clarify your instructions.

Contract Number	Telephone Number	Best Time To Call: ______ ☐ AM ☐ PM
Owner's Full Name *(First, Middle, Last or Trust/Entity)*		Owner's Date of Birth *(mm/dd/yyyy)*
Joint Owner's Full Name *(if applicable; First, Middle, Last)*		Joint Owner's Date of Birth *(mm/dd/yyyy)*

Owner's Residential Address	City/Town	State	Zip Code
Owner's Mailing Address *(if different from above)*	City/Town	State	Zip Code
Owner's Email Address			

Section B: Your Withdrawal Options

I wish to exercise the Terminal Illness Waiver Rider and withdraw the following without incurring any penalties and/or fees. I understand that proof of terminal illness must be provided and the withdrawal occurs on or after the first Contract Anniversary.

Please select from the following options:

☐ Withdrawal in the amount of $ __________

☐ A full surrender of the contract, which will exhaust all funds of the contract.

Section C: Tax Withholding

Please Note: This section is not applicable for custodial owned contracts.

C1: Federal Income Tax Withholding

Regardless of whether federal income tax is withheld, you are liable for taxes on the taxable portion of the payment. If you do not have enough withheld, you may be subject to tax penalties under the Estimated Tax Payment rules. **The company will withhold using the default rate of 10% unless you opt out of withholding below or make an alternate election on IRS Form W-4R.** This withholding election form and instructions can be obtained at www.irs.gov or by calling us at the number shown on page 1. Once a payment has been issued, withholding cannot be changed.

Withholding Election:

☐ **DO NOT WITHHOLD** federal income tax from my payment

☐ **WITHHOLD** the default rate of 10% from my payment for federal income tax

☐ **WITHHOLD** federal income tax based on the included IRS Form W-4R*

***If the IRS Form W-4R is not included with this form, then the default rate will be applied**

Section C: Tax Withholding *(continued)*

C2: State Income Tax Withholding

State withholding requirements vary widely and can be dependent upon factors such as the type of contract or distribution, whether federal withholding is being applied and the age of the payee. You are encouraged to consult a tax advisor or review your State Tax Department's website for requirements applicable to your situation before making your state withholding election. If you do not make an election or if your election does not meet the requirements mandated by your state of residence, including making the election on the state specific withholding election form if applicable, we will apply the state default or mandatory withholding rate.

☐ **DO NOT WITHHOLD** state income tax from my payment *(Must meet state requirements)*

☐ **WITHHOLD** the default rate from my payment for state income tax

☐ **WITHHOLD** the following amount or percentage from my payment for state income tax: ____________
(Must meet state requirements)

Section D: Authorization to Release Information

Name of Attending Physician

I authorize the physician referenced above to release information relevant to my condition and to provide such information to Forethought Life Insurance Company.

Patient's Signature ***(Please sign prior to submitting this form to your attending physician.)***

Section E: Medical Information *(To be completed by Attending Physician)*

Physician's Name	Telephone Number	Fax Number	
Street Address	City/Town	State	Zip Code
Diagnosis	Evidence of proof of the medical condition		

What is your relationship to patient other than as physician?

Is patient terminally ill and expected to die within 12 months or less? ☐ Yes ☐ No

Physician's Signature	Date *(mm/dd/yyyy)*

Forethought Life Insurance Company will not be responsible for payment of any fees associated with the completion of this form.

REQUIRED CERTIFICATION AND SIGNATURE(S) ON THE NEXT PAGE

Section F: Certification and Signature(s)

CERTIFICATION:
Taxpayer Identification Number *(must be completed)*

REQUIRED →	Owner's Social Security No./Taxpayer I.D.	Joint Owner's Social Security No.

US TAXPAYER CERTIFICATION:

By submitting this form, I am certifying under penalties of perjury, that:

1. The Taxpayer Identification Number that appears on this form is correct,
2. I have not been notified by the IRS that I am subject to backup withholding or I am no longer subject to backup withholding[1], and
3. I am a U.S. Citizen or other U.S. Person (including a person qualifying as a U.S. Resident Alien)

[1]If you are subject to back-up withholding, you must strike through statement number 2.

NON-RESIDENT ALIEN STATUS:

If you are a Non-Resident Alien, the US Taxpayer certification language above does not apply to you. Please check the box and provide your country of residence below.

☐ Under penalties of perjury, I certify that I am a Non-Resident Alien, and my country of residence is:_____________.

Taxable amounts paid to you will be subject to 30% withholding, unless you submit an IRS Form W-8, and are entitled to claim a reduced rate of withholding under the applicable US tax treaty.

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

Owner/POA/Custodian/Trustee Signature	Title *(if applicable)*	Date *(mm/dd/yyyy)*
Joint Owner/POA/Co-Trustee Signature *(if applicable)*	Title *(if applicable)*	Date *(mm/dd/yyyy)*
Spouse's Signature *(Required in the following community property states: AZ, CA, ID, LA, NM, NV, TX, WA, WI)* or check here if applicable ☐ Not Married		Date *(mm/dd/yyyy)*

This form can be submitted as follows:

U.S. Mail or Private Express Carrier:
Forethought Life Insurance Company
123 Town Square Place
PMB 711
Jersey City, NJ 07310

Submit Via Fax:
Please fax to (855) 299-0104

Submit Via E-mail:
GAOperations@email.gafg.com

Questions? Please contact us at:
(833) ASK-GA4U | (833) 275-4248

Our Website is:
www.globalatlantic.com

This information is intended to provide educational information about the features and mechanics of the product. It should not be considered, and does not constitute, personalized investment advice. The issuing insurance company is not an investment adviser. It's not acting in any fiduciary capacity with respect to any contract and/or investment.