Security Benefit®

Withdrawal Charge Waiver

Attn: Annuity Administration

Please type or print in black ink. Questions? Call our National Service Center at 1-800-238-9354.

1. General Account Information

Contract Number

Name of Annuitant
(First) (MI) (Last)

Address

City State Zip Code

Tax I.D. Number / Social Security Number

Phone Number (for confidential calls between 7:00am and 6:00pm CST)

Please complete the appropriate section of this form, have your physician complete and sign the Physician's Signature Section and return to Security Benefit.

IMPORTANT NOTE: This form must accompany each withdrawal requested under the Withdrawal Charge Waiver Option.

2. Hospital or Nursing Home Certification

I hereby certify that I have been confined to a "Hospital" or "Nursing Home Facility" for a minimum of the last 30 consecutive days; that I am making this withdrawal request during the period in which I am confined or no later than 91 days after the confinement period has ended.

X

Signature of Contract Owner Date (mm/dd/yyyy)

Name of Hospital/Nursing Home Facility

Address of Hospital/Nursing Home Facility

City State Zip Code

Date of Entry to Hospital/Nursing Home Facility

Expected Period of Confinement

3. Physician's Statement

I, _____
(Physician's Name)

a duly licensed physician, hereby certify that

X _____
(Contract Owner's Name)

X _____ _____
Signature of Physician Date (mm/dd/yyyy)

_____ _____ _____
Physician's First Name (MI) (Last)

_____
Address of Physician

_____
City

_____ _____
State Zip Code

_____
Physician's Phone Number

Additional comments:

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