AURORA
AN RGA COMPANY
Aurora National Life Assurance Company
PO Box 4336, Clinton, IA 52733-4336

PAYEE / ANNUITY INITIATION FORM

This form should be completed by the payee to initiate benefit payments upon the death of a Participant covered under the group contract. Any certificate issued to the Participant must be returned with this form if the certificate is available. Please return to: *Aurora National Life Assurance Company, P.O. Box 4336, Clinton, IA 52733-4336, ATTN: Client Services.*

NAME OF PLAN	DATE / /

PARTICIPANT DATA This section must be completed

NAME	SOCIAL SECURITY NUMBER --- ---
ADDRESS (Street, Apartment Number, City, State, Zip	

DATE OF BIRTH / /	DATE OF HIRE / /	DATE OF TERMINATION / /	DATE OF RETIREMENT / /

PAYEE INFORMATION

Indicate the purpose of your request by placing an "X" in the appropriate box and providing the requested information.

	I request to begin receiving the joint annuity benefit under the contract. (Applicable only if elected on the Benefit Election Form at time of retirement.)
	NAME OF JOINT ANNUITANT
	I request to begin receiving the balance of remaining period certain benefits.
	NAME OF BENEFICIARY
	I request payment of the death benefit applicable under the group contract. (Applicable only at the time of retirement and only if a lump sum benefit is available as a payment option or is included as part of the payment option chosen by the Participant)
	NAME OF BENEFICIARY
	I request payment of a cash withdrawal of the Participant's contributions. (Applicable only if a cash withdrawal of contributions is available under the group contract.)
	NAME OF BENEFICIARY

Please complete for the person who is to receive benefit payments

NAME	SOCIAL SECURITY NUMBER - -
ADDRESS (Street, Apartment Number, City, State, Zip)	

TELEPHONE NUMBER ( )	DATE OF BIRTH (Attach Copy of Birth Cer.) / /	RELATIONSHIP TO ANNUITANT

PAYMENT INFORMATION:

If you would like to have your monthly benefits deposited directly to a bank, please complete the attached authorization form, and return the copy to Aurora.

PAYEE/ ANNUITY INITIATION FORM

Proof of Loss Part I

INSTRUCTIONS

The following items are required for all claims:

- A copy of the death certificate showing cause of death.
- This claim form completed and signed by the claimant(s).

If the death occurred outside of the United States, we will require a Report of the Death of an American Citizen Abroad.

Special instructions and additional requirements may apply.

- If the beneficiary is the Estate of the Insured, we will also require evidence of the court appointed legal representative over the estate. Please provide the Tax ID number of the Estate of the Insured.
- If the beneficiary is a trust, we will also require a copy of the trust agreement and any amendments, including the signature page(s). Please note the Trustee Certification section of the claim form will also need to be completed by all trustees. Please use the trust's name when completing the Claimant Information section of the claim form and provide the Tax ID number of the trust.
- If the beneficiary is a minor, we will require evidence of court appointed guardianship of the Minor's Estate.
- If the contract is collaterally assigned, we will require a letter from the collateral assignee stating the balance due under the collateral assignment. If the collateral assignee is a corporation, please include a copy of the corporate resolution verifying who is authorized to sign on behalf of the corporation.
- If the primary beneficiary(ies) is (are) deceased, we will require a death certificate for each deceased beneficiary.
- If the contract has a split dollar agreement associated with it, we will require a copy of said agreement.
- Spousal Continuation and Five Year Deferrals – these options are not available if prohibited by contract language or federal law. The Defense of Marriage Act ("DOMA") defines "marriage," for federal purposes, as "a legal union between one man and one woman as husband and wife." In addition, DOMA defines "spouse" for federal purposes, as "a person of the opposite sex who is a husband or wife." Consequently, DOMA precludes recognition of marriages between same-sex partners under the Internal Revenue Code, which means that the favorable tax treatment provided by federal tax law to opposite-sex spouses is not available to same-sex spouses. For further information regarding federal tax laws, please consult a qualified tax advisor.

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

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 a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in 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 in 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 or 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 hereto 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 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 Signatures 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.

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 FOR IRS FORM W-9

This information is being collected on this form versus IRS form W-9 and will be used for supplying information to the Internal Revenue Service (IRS). Under penalty of perjury, I certify that 1) the tax ID number above is correct (or I am waiting for a number to be issued to me), 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 a 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). Please 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.

SIGNATURES

I/We do hereby make claim to said insurance, 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 insurance in force on the life in question, nor a waiver of its 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.

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

_____ _____

Signature of Claimant and Title Date

_____ _____

Signature of Second Claimant, if any, and Title Date

NOTARIAL ACKNOWLEDGMENT

State of _____)

County of _____) ss.

On _____, before me, _____, Notary Public, personally appeared _____ personally known to me (or proved to me on the basis of satisfactory evidence) to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they/ executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s),

Or the entity upon behalf of which the person(s) acted, executed the instrument.

WITNESS my hand and official seal.

Signature _____

(SEAL)

PAYEE / ANNUITY INITIATION FORM

TRUSTEE CERTIFICATION

TRUSTEE CERTIFICATION (to be completed only if trust is claiming proceeds)

COMPLETE THIS SECTION ONLY IF A TRUST IS CLAIMING BENEFITS.
Please include a copy of the trust agreement, including the signature page(s) and any amendments.

I/We, the undersigned trustee(s), represent and warrant that the copy of the trust agreement, which we will provide you pursuant to this certification, is a true and exact copy of said agreement, that said agreement is in full force and effect, and that we have the authority to make this certification.

Generation Skipping Transfer Tax Information – THIS MUST BE COMPLETED FOR PAYMENT

I/We the undersigned, on oath, deposes and states as follows with respect to the possible application of the Generation Skipping Transfer (GST) tax to the death benefit payment (Mark the appropriate item):

_____1. The GST tax does not apply because the death benefit is not included in the decedent's estate for federal tax purposes.

_____2. The GST tax does not apply because the GST tax exemption will offset the GST tax.

_____3. The GST tax does not apply because at least one of the trust beneficiaries is not a "skipped" person.

_____4. The GST tax does not apply because of the reasons set forth in the attached document (Please attach document setting forth the reasons why you believe the GST tax does not apply.)

_____5. The GST tax may apply. As a result, the death benefit payment IS subject to withholding of the applicable GST tax. Enclosed is the completed Schedule R-1 (Form 706) for submission to the Internal Revenue Service.

Name of Trust	Date of Trust Agreement
Date of all Amendments	Trust Tax ID Number

NOTARIAL ACKNOWLEDGMENT

State of _____)

County of _____) ss.

On _____, before me, _____, Notary Public, personally appeared _____ personally known to me (or proved to me on the basis of satisfactory evidence) to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they/ executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s),

Or the entity upon behalf of which the person(s) acted, executed the instrument.

WITNESS my hand and official seal.

Signature _____

(SEAL)