

Annuity Partial Withdrawal or Surrender Request

American Life Insurance Company ("Company") F.O.I. Box 51908, Lincoln, NE 68501 / 800-745-1102, Fax 402-467-1335

(This refers to Tax Identification Number)

Policy Number: _____

Name of Owner: _____ TIN/SSN: _____

Name of Joint Owner: _____ TIN/SSN: _____

1. Withdrawal 1174

The partial withdrawal amount you request will be the **GROSS AMOUNT**, unless otherwise indicated, which will include taxes withheld, if elected. The total amount will be increased or decreased by any applicable withdrawal charge and applicable market value adjustment. **The minimum partial withdrawal is \$100.** If after the partial withdrawal the remaining amount is less than the minimum specified in the policy, then the Accumulation Value will be surrendered instead of the requested amount.

Partial Withdrawal

in the amount of \$ _____, or Penalty Free withdrawal

2. Allocation of Withdrawal – Variable Only

A partial withdrawal will be taken on a pro-rata basis UNLESS you specify the sub-account(s) below: _____ \$ _____

3. Surrender 1180

Full Cash Surrender. I request the cash surrender value from the Company as payment in full of all rights, interest and claims in and under the above policy which is hereby surrendered for cancellation. Any applicable surrender charge and any Market Value Adjustment will be deducted in accordance with the policy provisions.

4. Systematic Withdrawal 1193 1257

Requested Amount \$ _____ Penalty Free Withdrawal Interest Only

Required Minimum Distribution. I request to begin the Required Minimum Distribution as set forth by the Internal Revenue Code. The Company is instructed to calculate my Required Minimum Distribution each year.

Effective month to begin automatic deposits: _____ Month / Year _____ Withdrawal Date: _____ Must be between the 1st and 28th of the month

Send Life Accumulation Corporate Dividends more than 30 Years Younger – Corporate Date of Birth: _____

5. Frequency

Withdrawal or Surrender Distribution – Only One Deposit: ADI (default) or Wire Transfer (214 fee)

Systematic Withdrawal Distributions paid by Direct Deposit (ADR): Monthly (default) Quarterly Semi-Annually Annually

Financial Institution Account Information for Direct Deposit to		
Name of Account Owner:	Account Number:	Routing Number:
Address:		
Telephone Number:	Type of Account: <input type="checkbox"/> Checking (check needed check) <input type="checkbox"/> Savings	
Name of Financial Institution:		

By signing this form, I authorize the Company to deposit funds by electronic funds transfer to the account and financial institution reflected on this form. I further authorize the financial institution to debit my account and to refund any overpayment made by the Company. This authorization will remain in effect until the Company receives written notification of each change, in sufficient time to act.

6. Additional Instructions:

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Table of Contents Annuity Partial Withdrawal Or Full Surrender Request Geba

1. Understanding the eBook Annuity Partial Withdrawal Or Full Surrender Request Geba
 - The Rise of Digital Reading Annuity Partial Withdrawal Or Full Surrender Request Geba
 - Advantages of eBooks Over Traditional Books
2. Identifying Annuity Partial Withdrawal Or Full Surrender Request Geba
 - Exploring Different Genres
 - Considering Fiction vs. Non-Fiction
 - Determining Your Reading Goals
3. Choosing the Right eBook Platform
 - Popular eBook Platforms
 - Features to Look for in an Annuity Partial Withdrawal Or Full Surrender Request Geba
 - User-Friendly Interface
4. Exploring eBook Recommendations from Annuity Partial Withdrawal Or Full Surrender Request Geba
 - Personalized Recommendations
 - Annuity Partial Withdrawal Or Full Surrender Request Geba User Reviews and Ratings

- Annuity Partial Withdrawal Or Full Surrender Request Geba and Bestseller Lists
- 5. Accessing Annuity Partial Withdrawal Or Full Surrender Request Geba Free and Paid eBooks
 - Annuity Partial Withdrawal Or Full Surrender Request Geba Public Domain eBooks
 - Annuity Partial Withdrawal Or Full Surrender Request Geba eBook Subscription Services
 - Annuity Partial Withdrawal Or Full Surrender Request Geba Budget-Friendly Options
- 6. Navigating Annuity Partial Withdrawal Or Full Surrender Request Geba eBook Formats
 - ePub, PDF, MOBI, and More
 - Annuity Partial Withdrawal Or Full Surrender Request Geba Compatibility with Devices
 - Annuity Partial Withdrawal Or Full Surrender Request Geba Enhanced eBook Features
- 7. Enhancing Your Reading Experience
 - Adjustable Fonts and Text Sizes of Annuity Partial Withdrawal Or Full Surrender Request Geba
 - Highlighting and Note-Taking Annuity Partial Withdrawal Or Full Surrender Request Geba
 - Interactive Elements Annuity Partial Withdrawal Or Full Surrender Request Geba
- 8. Staying Engaged with Annuity Partial Withdrawal Or Full Surrender Request Geba
 - Joining Online Reading Communities
 - Participating in Virtual Book Clubs
 - Following Authors and Publishers Annuity Partial Withdrawal Or Full Surrender Request Geba
- 9. Balancing eBooks and Physical Books Annuity Partial Withdrawal Or Full Surrender Request Geba
 - Benefits of a Digital Library
 - Creating a Diverse Reading Collection Annuity Partial Withdrawal Or Full Surrender Request Geba
- 10. Overcoming Reading Challenges
 - Dealing with Digital Eye Strain
 - Minimizing Distractions
 - Managing Screen Time
- 11. Cultivating a Reading Routine Annuity Partial Withdrawal Or Full Surrender Request Geba
 - Setting Reading Goals Annuity Partial Withdrawal Or Full Surrender Request Geba
 - Carving Out Dedicated Reading Time
- 12. Sourcing Reliable Information of Annuity Partial Withdrawal Or Full Surrender Request Geba
 - Fact-Checking eBook Content of Annuity Partial Withdrawal Or Full Surrender Request Geba
 - Distinguishing Credible Sources

13. Promoting Lifelong Learning
 - Utilizing eBooks for Skill Development
 - Exploring Educational eBooks
14. Embracing eBook Trends
 - Integration of Multimedia Elements
 - Interactive and Gamified eBooks

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