Activities of daily living - Lifetime income rider multiplier form

MIDLAND NATIONAL®

CLEAR FORM

P.O. Box 10385, Des Moines, IA 50306-0385

To be completed to begin payments under the ADL multiplier provided in your Annuity Contract or rider.

Altered forms, including but not limited to correction fluid, strike out, or photocopies will not be accepted. Please ensure all pages of this form are submitted along with the **Authorization for release of health-related information** and all sections are completed accurately to ensure prompt processing of your request. Failure to do so may result in a delay of the withdrawal.

1. Account information

Annuity Policy/Contract number

Owner name	Owner Social Security number
Joint Owner name	Joint Owner Social Security number

2. Physician information

Once we receive this form with all information completed we will send the **attending physician statement for election of benefits under the activities of daily living (ADL) rider** request to your Physician to be completed. This form is required to be completed and returned by your physician prior to completion of review for eligibility. In order to expedite the process we are requesting you provide all physician information below.

Physician name	Phone number
Street address	Fax number

City/State/ZIP

Date first treated (mm/dd/yyyy)	Date last treated (mm/dd/yyyy)

3. Certification

Activities of daily living - definitions under our Contract

1. "Bathing" means the ability to wash oneself by sponge, bath, or in either a tub or shower, including the task of getting into or out of the tub or shower.
2. "Continence" means the ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).
3. "Dressing" means putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.
4. "Eating" means the ability to feed oneself by getting food into the body from a receptacle (such as plate, cup or table) or by a feeding tube or intravenously.
5. "Toileting" means getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
6. "Transferring" means moving into or out of a bed, chair or wheelchair.

I certify that as of _____/_____/_____ I am unable to perform the following selected ADLs: (The date entered must be at least 90 days prior to the date this form is completed.)

☐ Bathing ☐ Continence ☐ Dressing ☐ Eating ☐ Toileting ☐ Transferring

I certify that the inability to perform the selected ADLs above is: ☐ Temporary ☐ Permanent

4. Withdrawal information

Your ADL multiplier will follow the same frequency as you elected on the Lifetime income payment election form.

Name of Owner	Name of Joint Owner

I acknowledge that payments will not begin until the ADL benefit waiting period has elapsed and we have received your **attending physician's statement for election of benefits. (Initial here)** _____

I acknowledge that I must re-certify eligibility every Contract year, up to the contractual maximum number of years. **(Initial here)** _____

5. Acknowledgment and signature(s)

CA Residents only: For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance 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.

All Residents: I/We hereby acknowledge and understand that:

- By signing this form indicates that each Owner has read, understands and agrees to the information provided throughout the form;
- This form must be fully completed and failure to complete any portion of this form may delay the processing of the request.

Taxpayer certification

Under penalties of perjury, my signature certifies that:

1. The number shown on this form is my correct taxpayer identification number (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, (b) I have not been notified by the Internal Revenue Service 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;
3. I am a U.S. citizen or U.S. resident alien; and
4. I am exempt from Foreign Account Tax Compliance Act (FATCA) reporting.

Owner signature/assignee	Date (mm/dd/yyyy)
Joint Owner signature/assignee	Date (mm/dd/yyyy)
Spousal signature*	Date (mm/dd/yyyy)

*In some states, community property laws or similar laws may apply when you are in a marriage or other domestic relationship with another person. Midland National makes no representation regarding the applicability of community property laws or the validity of the requested transaction. You are encouraged to consult with your legal counsel with any community property questions prior to completing this transaction. If you do not indicate that you are married, Midland National will rely on your representation and proceed as if you are not married, and no community property right exists. You understand and agree that Midland National has no duty to inquire further about any such community property interest and you agree to indemnify and hold Midland National harmless from any consequences relating to any community property interests and this transaction. By signing this form, you are certifying that the information you provided in this section is true and correct.

Note: Be sure to fill out and return the Authorization for release of health-related information along with this form.

Authorization for release of health-related information

P.O. Box 10385, Des Moines, IA 50306-0385

CLEAR ALL

This authorization complies with the HIPAA privacy rules.

Name of proposed insured (please print first name, last name)	Date of birth (mm/dd/yyyy)

I authorize any health plan, physician, dental practitioner, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years ("my providers") to disclose my entire medical record and any other protected health information concerning me to Midland National® Life Insurance Company (Midland National) and its agents, employees, and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct my providers to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this authorization so that Midland National may:
1) underwrite my application for coverage, determine eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with Midland National.

This authorization shall remain in force for 30 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to Midland National at PO Box 10385, Des Moines, IA, 50306-0385, Attention: Client Services. I understand that a revocation is not effective to the extent that any of my providers has relied on this authorization or to the extent that Midland National has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that my providers cannot deny me treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I alter, revoke, or refuse to sign this authorization to release my complete medical record, Midland National may not be able to process my application, or if coverage has been issued, may not be able to make any benefit payments. I acknowledge by my signature below, that I have a right to receive, and have in fact received, a copy of this authorization.

Signature of proposed insured or personal representative	Date (mm/dd/yyyy)

If you are the personal representative of the proposed insured, describe the scope and/or basis of your authority to act on the insured's behalf:

Send original with application – give a copy to proposed insured.

AGENT INSTRUCTION: Two copies needed.
Return this signed original to the Home Office, leave a signed copy with the proposed insured.

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