WPALife®
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Annuity Rider Withdrawal Charge Waiver Claim Form

For use with the Member Emergency Access Rider (ICC225 ACCESS RDR) and the Rider to Waive Applicable Surrender Charges Due to Terminal Illness, Confinement in an Eligible Nursing Home, or Receipt of Home Health Care Services (ICC225 NH RDR)

CERTIFICATE AND ANNUITANT INFORMATION

Certificate Number: Rider Date of Issue (MM/DD/YYYY): / /

Annuitant Full Name (First, Middle, Last):

Date of Birth (MM/DD/YYYY): / / Sex: ☐ M ☐ F

Social Security Number (last 4 digits):

Residence Address (Street, City, State, ZIP):

Daytime Telephone: ( ) - Mobile Telephone: ( ) -

Email Address:

TYPE OF CLAIM

Indicate the qualifying event for which a waiver of withdrawal charges is being requested by selecting one of the events listed below. Only one event may be selected per claim. Each rider may be exercised only once.
Obtaining Attending Physician's Statement is the responsibility and at the cost of the annuitant.

Under the Member Emergency Access Rider (ICC225 ACCESS RDR):

☐ A. Involuntary loss of employment for more than 90 days.

☐ B. Disability due to accidental loss of arm, leg, hand or foot, or sight in at least one eye.

☐ C. Hospitalization of five (5) or more days due to accident or illness.

Under the Rider to Waive Applicable Surrender Charges Due to Terminal Illness, Confinement in an Eligible Nursing Home, or Receipt of Home Health Care Services (ICC225 NH RDR):

☐ D. Diagnosis of a Terminal Illness (life expectancy of twelve (12) months or less).

☐ E. Confinement in an Eligible Nursing Home for at least ninety (90) days.

☐ F. Receipt of Home Health Care Services due to Impairment in two (2) of the six (6) Activities of Daily Living for at least ninety (90) days.

EVENT DETAILS

**** Complete only the subsection that corresponds to the event. ****

A. Involuntary Loss of Employment

Name of Former Employer:

Employer Address (Street, City, State, ZIP):

Date Employment Ended: / / Reason for Separation:

Has unemployment exceeded 90 days? ☐ Yes ☐ No

If Yes, date of termination: / /

Required documentation: Separation notice or termination letter from the employer

B. Disability Due to Accidental Loss

Describe the accidental loss:

Date of Accident: / /

Brief description of how the accident occurred:

Required documentation: Attending Physician's Statement confirming the loss

C. Hospitalization of Five (5) or More Days

Name of Hospital or Facility:

Hospital Address (Street, City, State, ZIP):

Admission Date: / / Discharge Date: / /

Total Days of Inpatient Confinement:

Reason for Hospitalization (diagnosis or condition):

Required documentation: Hospital admission and discharge summary, attending physician's certification of inpatient confinement.

D. Terminal Illness

Diagnosis:

Date of Diagnosis: / / Date of Physician Certification: / /

Required documentation: Attending Physician's Statement completed by the diagnosing Physician or a Physician who provided medical care to the annuitant in connection with the Terminal Illness, certifying a life expectancy of twelve (12) months or less. WPALife reserves the right to obtain a second medical certification at its expense.

EVENT DETAILS

**** Complete only the subsection that corresponds to the event. ****

E. Confinement in an Eligible Nursing Home

Name of Nursing Home:

Nursing Home Address (Street, City, State, ZIP):

Date Confinement Began: / /

Is the annuitant currently confined? ☐ Yes ☐ No

If No, date of discharge: / /

Required documentation: Attending Physician's Statement completed by a Physician who provided medical care to the annuitant in connection with the confinement

F. Receipt of Home Health Care Services

Name of Home Health Care Agency:

Agency Address (Street, City, State, ZIP):

State License Number: Agency Telephone: ( ) -

Date ADL Impairment Began: / /

Date Home Health Care Services Began: / /

Required documentation: Attending Physician's Statement certifying Impairment in two (2) of the six (6) Activities of Daily Living listed below and that the Impairment is expected to not be temporary; Agency service records or care plan; and evidence that the Agency is licensed to provide Home Health Care Services in the state in which services are provided.

The Activities of Daily Living are:

1) Bathing: washing yourself by sponge bath or in a tub or shower, including the tasks of getting into or out of the shower;

2) Dressing: putting on and taking off all items of clothing and any required braces, fasteners or artificial limbs;

3) Transferring: moving into and out of a bed, chair or wheelchair;

4) Toileting: getting to and from the toilet, getting on and off the toilet and performing related personal hygiene;

5) Continence: ability to maintain control of bowel or bladder function or, when not able to maintain control, ability to perform related personal hygiene (including caring for catheter or colostomy bag); and

6) Eating: feeding yourself by getting food into the body from a receptacle (cup, plate or table) or by feeding tube intravenously.

PHYSICIAN'S CERTIFICATION

I certify that I am a Physician licensed to practice medicine in the United States or one of its territories, that I am acting within the scope of my license, and that I am not the annuitant, a beneficiary under the contract, or a member of the annuitant's immediate family.

Patient (Annuitant) Name:

Physician Name (Print):

Office Address (Street, City, State, ZIP):

Telephone: ( ) - Medical Specialty:

State of License: License Number:

I also certify under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge.
(SEE STATE FRAUD WARNING NOTICES)

Physician Signature: Date: / /

WITHDRAWAL REQUEST*

The withdrawal requested under this claim is subject to the Maximum Withdrawal Amount shown on the applicable Rider Schedule (the lesser of 50% of Account Value or $100,000, plus the amount available under the penalty-free partial withdrawal provision in the certificate). Indicate the amount requested:

☐ A specific dollar amount: $_____

☐ A specific percentage of Account Value: _____ %

☐ The Maximum Withdrawal Amount available under the rider

***IRS form W-4R and photo ID must be included with all withdrawal requests.**

ANNUITANT SIGNATURE

I certify that the information provided in this claim form is true and complete to the best of my knowledge and belief, and I request a waiver of withdrawal charges under the rider. (SEE STATE FRAUD WARNING NOTICES)

Annuitant Signature: Date: / /

Printed Name: Certificate Number:

If signed by an authorized representative (Power of Attorney, conservator, or guardian), attach a copy of the legal documentation evidencing authority.

Representative Signature: Date: / /

Printed Name: Capacity:

If you reside in a community property state and are currently married, your spouse must sign below acknowledging their full understanding of this withdrawal request.

Spouse's Signature: Date: / /

Printed Name:

ADDITIONAL DOCUMENTS REQUIRED

☐ Signed Authorization to Release Medical Records Form (if medical claim)

☐ Copy of driver's license or other state issued identification

☐ IRS Form W-4R

Mail completed forms and supporting documentation to:

WPALife
Attn: Annuity Department
709 Brighton Road
Pittsburgh, PA 15233-1821

or email to: **annuity@wpalife.org**

STATE FRAUD WARNING NOTICES

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines, or confinement in prison, or any combination thereof.Alaska: Any person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arizona: For your protection Arizona law requires the following statement to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Arkansas: 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.

California: For your protection, California law requires the following 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 state prison.

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 with 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.

Delaware: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information, is guilty of a felony.

District of Columbia: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

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.

Idaho: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

Indiana: A person who knowingly and with intent to defraud an insurer, files a statement of claim containing any false, incomplete, or misleading information, commits a felony.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

Louisiana: 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.

Maine: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

STATE FRAUD WARNING NOTICES

Minnesota: A person who files a claim with intent to defraud, or helps commit fraud against an insurer, is guilty of a crime.

New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

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.

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.

Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Oregon: Any person who knowingly and with intent to defraud or solicit another to defraud an insurer: (1) by submitting an application, or (2) by filing a claim containing a false statement as to any material fact thereto, may be committing a fraudulent insurance act, which may be a crime and may subject the person to criminal and civil penalties.

Pennsylvania: 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 subjects such person to criminal and civil penalties.

Rhode Island: 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.

Tennessee: 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.

Texas: 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 state prison.

Utah: Any person who knowingly presents false or fraudulent underwriting information, files or causes to be filed a false or fraudulent claim for disability compensation or medical benefits, or submits a false or fraudulent report or billing for health care fees or other professional services is guilty of a crime and may be subject to fines and confinement in state prison.

Virginia: 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.

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 may include imprisonment, fines, or denial of insurance benefits.

West Virginia: 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.