



American National Life Insurance Company of New York

### Annuity Service Request Form

American National Life Insurance Company of New York  
344 Route 9W, Glenmont, NY 12077

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Administrative Address:  
One Moody Plaza, Galveston, TX 77550-7999 Business: (866) 490-3163  
PO Box 1890, Galveston, TX 77553-1890

**POLICY NUMBER:** \_\_\_\_\_ **ANNUITANT:** \_\_\_\_\_

**Note: The existing Owner and Joint Owner (if applicable) must authorize all changes or requests by providing their signature in Section 8.**

**1. CHANGE OF NAME:** Only complete this section if the Annuitant, Owner, or Beneficiary's name has changed. Please complete section 3 for a Change of Annuitant, section 4 for a Change of Ownership, or section 5 for a Change of Beneficiary.

Annuitant  Owner  Beneficiary

Current Name: \_\_\_\_\_ New Name: \_\_\_\_\_

Reason for Change:  Marriage  Divorce  Court Order  Correction  Other: \_\_\_\_\_

**2. CHANGE OF ADDRESS:**

Annuitant  Owner  Beneficiary

Old Address: \_\_\_\_\_ New Address: \_\_\_\_\_

Mailing Address \_\_\_\_\_ Mailing Address \_\_\_\_\_

City State Zip City State Zip

**3. CHANGE OF ANNUITANT:** Only applies to contracts where a death benefit is not paid upon Annuitant's death.

I/We hereby request that the Annuitant be changed:

From: \_\_\_\_\_ To: \_\_\_\_\_

SSN  TIN  EIN \_\_\_\_\_  SSN  TIN  EIN \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Mailing Address \_\_\_\_\_ Mailing Address \_\_\_\_\_

City State Zip City State Zip

**4. CHANGE OF OWNERSHIP:**

**Complete this section to change the Owner:**

Existing Owner's Information:

Name: \_\_\_\_\_

SSN  TIN  EIN \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Mailing Address \_\_\_\_\_

City State Zip

New Owner's Information:

Name: \_\_\_\_\_

SSN  TIN  EIN \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Mailing Address \_\_\_\_\_

City State Zip

**Complete this section to change and/or add a Co-Owner:**

Existing Co-Owner's Information (If Co-Owner is changing):

Name: \_\_\_\_\_

SSN  TIN  EIN \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Mailing Address \_\_\_\_\_

City State Zip

New Co-Owner's Information:

Name: \_\_\_\_\_

SSN  TIN  EIN \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Mailing Address \_\_\_\_\_

City State Zip

**Note: A change in ownership may result in adverse tax consequences. Consult your tax advisor for guidance.**



**5. CHANGE OF BENEFICIARY:**

I/We revoke existing designations and subject to any existing assignment, make the following Beneficiary and Contingent Beneficiary Designations:

Name of Primary Beneficiary: \_\_\_\_\_

Name of Contingent Beneficiary: \_\_\_\_\_

SSN  TIN  EIN \_\_\_\_\_

SSN  TIN  EIN \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Mailing Address \_\_\_\_\_

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Designation percentages must total 100%. Complete Additional Beneficiary Page (Form ANY-10073 if additional space is needed. Unless otherwise directed, the Beneficiaries in a class will share equally.)

**6. DISTRIBUTION REQUEST:** A 10% Pre-Mature Distribution Penalty may be assessed if the Owner of this contract is under age 59½. Please refer to a tax consultant for further information.

**PARTIAL WITHDRAWAL**

I hereby request a one-time withdrawal for |\$ \_\_\_\_\_ (\$250 minimum)

**10% SURRENDER-CHARGE FREE WITHDRAWAL**

I hereby request a withdrawal of 10% of the annuity value as of the beginning of the contract year.

**INTEREST ONLY SYSTEMATIC WITHDRAWALS**

I hereby request interest withdrawals from the contract on a systematic basis.

**FIXED AMOUNT SYSTEMATIC WITHDRAWALS**

I hereby request systematic withdrawals in the amount of |\$ \_\_\_\_\_ from the contract on a systematic basis.

**CONTRACT SURRENDER**

I hereby request a surrender of the entire contract for its full cash surrender value.

If you elected to receive distributions on a systematic basis, please specify the frequency in which the funds should be disbursed.

Monthly  Quarterly  Semiannual  Annual Date of First Payment \_\_\_\_\_

**A voided check must accompany this form if you have completed a request for a distribution. Distributions will be processed as secure ACH remittances directly into the account of your choice at your financial institution.**

**7. WITHHOLDING INSTRUCTIONS:** Minimum Withholding is 10% and will be withheld if no election is made below.

Do not withhold taxes. I understand I am responsible for the payment of estimated taxes and that I may incur penalties if my payments are not enough.

I want to have \_\_\_\_\_% Federal Income Tax withheld from the taxable amount of the distribution.

I want to have \_\_\_\_\_% State Income Tax withheld from the taxable amount of the distribution. (If applicable)

Taxpayer Identification Number: \_\_\_\_\_  SSN  TIN  EIN

**IRS** regulations state that if your taxpayer identification number (social security or employer identification number) is not furnished, we will be required to withhold at the current applicable withholding rate. Under penalty of perjury, I certify 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), and

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 failure to report all interest/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).

**NOTE: You may be subject to penalties under the estimated tax payment rules if enough tax has not been paid through either your estimated tax payment or withholding.**



**8. SIGNATURES:**

The Contract Owner must sign this form. For ownership changes, the present Contract Owner and new Contract Owner must sign this form. The effective date of this request will be the date received in the Administrative Office of American National Life Insurance Company of New York.

Current Owner Signature - Required

Date of Signature

Phone Number

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Joint Owner Signature - if applicable

Date of Signature

\_\_\_\_\_

\_\_\_\_\_

New Owner Signature - if applicable

Date of Signature

\_\_\_\_\_

\_\_\_\_\_

New Joint Owner Signature - if applicable

Date of Signature

\_\_\_\_\_

\_\_\_\_\_

Witness Signature

Date of Signature

\_\_\_\_\_

\_\_\_\_\_

**FOR ADMINISTRATIVE OFFICE USE ONLY**  
**AMERICAN NATIONAL LIFE INSURANCE COMPANY OF NEW YORK HAS RECORDED THE CHANGE REQUESTED**

**DATED ON** \_\_\_\_\_ **BY** \_\_\_\_\_  
**EFFECTIVE DATE** **REGISTRAR**