



American National Life Insurance Company of New York

IRA Required Minimum Distribution Election Form

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

page 1 of 1

Administrative Address:

One Moody Plaza, Galveston, TX 77550-7999 Business: (866) 490-3163
P.O. Box 1890 Galveston, TX 77553-1890



Use this form to authorize American National Life Insurance Company of New York to automatically pay you an annual withdrawal to satisfy IRS Required Minimum Distribution requirements. If you choose our Automatic Withdrawal Option our automated system will calculate your annual lifetime required amount based on the 2002 Final Regulations. Distributions will be deposited into an account of your choice. Please attach a copy of a voided check with the completed form.

1. ANNUITANT INFORMATION

ANNUITANT

POLICY NUMBER

ADDRESS

CITY/STATE/ZIP

SOCIAL SECURITY NUMBER

DATE OF BIRTH

2. OWNER INFORMATION, IF DIFFERENT FROM ANNUITANT

OWNER

SOCIAL SECURITY NUMBER

ADDRESS

CITY/STATE/ZIP

3. LIFE EXPECTANCY CALCULATION (CHECK A OR B)

- A. SINGLE LIFE EXPECTANCY *(Unless you qualify for and would like to elect "B" below, this is the only option available to you.) This indicates that the RMD is based only upon the contract owner's life factor and will be calculated using the Uniform Lifetime Table as permitted by the IRS.*
- B. JOINT LIFE EXPECTANCY - Recalculated annually *(This option is only available if your spouse is your sole primary beneficiary and is more than 10 years younger than you.)*

NAME OF SPOUSE

DATE OF BIRTH

SOCIAL SECURITY NUMBER

4. DISTRIBUTION PAYMENT INSTRUCTIONS

WOULD YOU LIKE TO PARTICIPATE IN OUR AUTOMATED REQUIRED DISTRIBUTION PROGRAM?

- A. YES. Please automatically re-calculate and send my distribution each year.
- B. NO. I only want to take this year's required distribution.
- C. NO. I wish to satisfy my RMD from other source.

If you selected option A or B, please indicate the start date and frequency for which you would like to receive your distribution payments. If no frequency is selected, the default will be Annual.

Start Date: _____ (Month) _____ (Day) _____ (Year)

Frequency: Annual Semi-Annual Quarterly Monthly

5. WITHHOLDING INSTRUCTIONS - If election is not made, we will withhold a mandatory 10%.

- 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 10% Federal Income Tax withheld from the taxable amount of the distribution. (You may also designate an additional amount below.)
- I want the following additional percentage withheld from the distribution _____ % + 10 % = _____ %
- I want the following percentage withheld for state withholding _____ %. (If applicable)

I authorize American National Life Insurance Company of New York to calculate and distribute my Required Minimum Distribution to me per my election above.

OWNER

DATE



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

page 1 of 3

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**