



**Affiliates:**  
Annuity Investors Life Insurance Company®  
Manhattan National Life Insurance Company

**Administrator for Life Insurance and Annuities:**  
Cigna National Health Insurance Company  
Continental General Insurance Company®  
Loyal American Life Insurance Company®  
Provident American Life & Health Insurance Company

**PO Box 5416, Cincinnati OH 45201 / 888-863-5891 / 800-859-0021 Fax**  
**Overnight Address: 191 Rosa Parks St, Cincinnati OH 45202**

## SURRENDER REQUEST FORM

<b>Insured's Name :</b>	<b>Policy Number:</b>
<b>Owner's Name</b>	

I hereby apply for the cash surrender value of the above policy. In consideration of the payment to be made to me of the cash surrender value, I herewith surrender the policy to the Company for cancellation of all insurance thereunder and hereby release and forever discharge the Company from all claims under said surrendered policy. The election to surrender the policy shall not be effective until this application and the policy (or suitable evidence of lost policy) are received by the Company at the Home Office in Cincinnati, Ohio, and when so received, the Company's liability under said policy, except for the amount of cash value, shall cease.

Dated at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.  
(City) (State)

\_\_\_\_\_  
Policyowner (Written Signature)

\_\_\_\_\_  
Social Security Number (Policyowner)

\_\_\_\_\_  
Policyowner's Spouse (Written Signature – If applicable)

\_\_\_\_\_  
Date

### NOTICE OF WITHHOLDING ON DISTRIBUTIONS OR WITHDRAWALS

The distributions you receive from the above policy are subject to Federal Income Tax withholding and State Income Tax withholding, where applicable, unless you elect not to have withholding apply. You may elect not to have withholding apply to your distribution by checking the appropriate box below and returning it to our office.

If you do not respond by the date your distribution is scheduled to be made, Federal Income Tax and State Income Tax, where applicable, will be withheld from the taxable portion of your distribution.

If you elect not to have withholding apply to your distribution payments, you may be responsible for payment of estimated tax. You may incur penalties under the estimated tax rules if your withholding and estimated tax payments are not sufficient.

### ELECTION FOR PAYEE OF NON-PERIODIC PAYMENTS

- I have read the above information and I DO NOT want to have Federal Income and State Income Taxes, where applicable, withheld from my distribution.
- I have read the above information and I DO want to have Federal Income and State Income Taxes, where applicable, withheld from my distribution.

Please Note: Where we have indicated that this is a tax-qualified plan, distribution of the policy proceeds may adversely affect the deferred status of the policy. We urge you to consult your tax advisor regarding the taxation of any distribution prior to reaching a final decision regarding this transaction.

### AFFIDAVIT PERTAINING TO LOST POLICY

(Complete only if you are unable to locate your original policy)

I, \_\_\_\_\_, the undersigned, certify that I am the owner of above policy number issued or assumed by MassMutual Ascend Life Insurance Company. I further certify that the policy has been lost or destroyed and I have no knowledge as to its whereabouts; that no person or persons, corporation, or association has any claim or interest in said policy, by virtue of any sale, assignment, or pledge thereof.

I will indemnify and hold harmless MassMutual Ascend Life Insurance Company, its successors and assigns from and against any and all liability, loss, damages, judgments, costs, charges, counsel fees, and expenses of every nature and kind which it does sustain by reason of accepting this statement in lieu of the actual policy. I agree that the original policy, if it later comes into my possession, shall be returned promptly to MassMutual Ascend Life Insurance Company.

\_\_\_\_\_  
Policyowner Signature (Written)

\_\_\_\_\_  
Date