



Nassau Life and Annuity Company (the Company)
 Nassau Life Insurance Company (the Company)
 PHL Variable Insurance Company (the Company)
 Nassau Life and Annuity Insurance Company (the Company)

**Required Minimum Distribution
 (RMD) Election Form**
Quick Reference



Enclosed is the RMD form you requested. In order for your request to be processed in a timely manner, **please read the enclosed material thoroughly and follow instructions carefully** when completing any form.

Items Enclosed

RMD Form	<ul style="list-style-type: none"> • Be sure to complete applicable sections A - D and section G of the RMD Election Form to let us know how you wish to fulfill your obligation to begin Required Minimum Distributions. Also, please read all sections. • Form must be dated in order to process your request.
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Contact Information	US Mail PO Box 22012 Albany NY 12201-2012	Shipping/Overnight 15 Tech Valley Drive, Suite 201 East Greenbush NY 12061-4142	Phone (800) 541-0171 Fax (321) 400-6317
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**The Company does not provide individual tax or financial advice.
 For advice about your individual situation, please consult a tax or financial advisor.**



A. General Information

Contract Number | Owner Name (Please Print) | Phone #

IMPORTANT! Failure to return this form will result in further action as outlined in your contract.

Distribution Option (select only one):

- Option 1: I elect to receive my Required Minimum Distribution, calculated per IRS guidelines, from the annuity contract number listed above. This amount will be recalculated annually. Complete Sections B through G.
Option 2: I will satisfy this and future Required Minimum Distribution(s) from a source other than or in addition to the annuity contract number(s) listed above. Complete Section G.
Option 3: I elect to annuitize my contract and begin receiving annuity payments. Upon receipt of this form, the Company will provide a list of annuity payment options and the values those options represent. Complete Section G.

B. Required Minimum Distribution Payment Options

- 1. Method of Distribution - Check one of the two payment methods listed below. (If none checked, will be mailed to the address of record).
Option 1: Check mailed to address of record.
Option 2: Direct Deposit. Please complete the attached Direct Deposit form (OL4020). Note: If the form is not returned, account cannot be validated, or any requirements are missing, a check will be mailed to your address of record. Additional direct deposit disclosures can be found on the Direct Deposit form (OL4020).
2. Distribution Frequency - Monthly Quarterly Semi-Annually Annually (if nothing is checked monthly will apply)
RMD payments are mandated when you reach the age of requirement under IRS guidelines. If you would like your RMD to begin on a specific date, please indicate the start date (month/year). Please note: If your first RMD is taken during your IRS Grace Period, your first RMD will be paid in one annual amount.
a. RMDs will be on the payout mode selected above. If not marked, will default to monthly.
b. Withdrawals may affect the benefit provided by any living benefit rider (i.e. GMAB, GMIB, GMWB). Care should be taken to coordinate the timing of the RMD distribution with the requirements of any living benefit rider; failure to do so may result in additional charges or reduction in benefits.
c. For contracts issued after February 15, only the RMD for the subsequent calendar year is used in determining the amount that can be withdrawn without fees and charges. Care should be taken in requesting an RMD from the contract for the first calendar year if the issue date is after February 15. Please refer to your Disclosure Statement for impacts an RMD can have on your contract and rider benefits.

C. Spousal Beneficiary Information

Is your spouse the Primary Beneficiary for your contract? Yes No
If Yes, provide spouse's: Name Date of Birth Social Security Number

NOTE: This information does not change your beneficiary. If you wish to change your beneficiary, please submit a Designation of Beneficiary, form OL122A.

If you reside in a community property state (AK, AZ, CA, ID, LA, NM, NV, TX, WA, WI) and your spouse is not the Beneficiary, the spouse may need to consent to the non-spouse beneficiary designation. The Contract Owner should consult with legal counsel regarding this designation. Should spousal consent be required, we will not be liable for any consequences resulting from the failure of the Owner to obtain proper consent.

D. Federal/State Tax Withholding

I am aware that the Federal/State Income Tax Withholding Election form (OL4753) is required to process this request and has been completed and returned with this form.

E. Withholding Notice Information

Basic Information. Generally, income tax withholding applies to the taxable part of payments made from pension, annuity, and individual retirement arrangements (IRAs). The method and rate of withholding depend on (a) the kind of payment you receive; (b) whether the payments are delivered outside the United States; and (c) whether the recipient is a nonresident individual. See IRS Form W-4P for special withholding rules that apply to payments outside the United States and payments to foreign persons.

Caution. There are penalties for not paying enough federal or state income tax during the year, either through withholding or estimated tax payments.
Periodic payments. Withholding from periodic payments of a pension or annuity is figured in the same manner as withholding from wages. Periodic payments are made in installments at regular intervals over a period of more than 1 year. If you do fail to provide us the correct social security number (SSN), we must withhold as if you are single claiming zero withholding allowances even if you checked the box on line 1 to have no income tax withheld. Mandatory state withholding may also be required.

Revoking previous election. At any time, you can chose to change your withholding election by completing form OL4753 and submitting it to the Company. Until revoked or changed, your current election stays in effect.

Statement of Federal Income Tax Withheld From Your Pension or Annuity. By January 31 of next year, we will furnish a statement to you on Form 1099-R, Distributions From Pensions, Annuities, Retirement or Profit-Sharing Plans, IRAs, Insurance Contracts, etc., showing the total amount of your pension or annuity payments and the total federal income tax withheld during the year. If you are a foreign person who has provided your payer with Form W-8BEN, your payer instead will furnish a statement to you on Form 1042-S, Foreign Person's U.S. Source Income Subject to Withholding, by March 15 of next year.

Further information. For more federal information, see IRS Publication 505, Tax Withholding and Estimate Tax, available at www.irs.gov. For state information, see each state's website.

F. Request for Maturity Date Postponement and Release and Indemnification Agreement

The undersigned requests that the Maturity Date of the above referenced annuity contract be postponed until the maximum maturity date as outlined in the contract.

The undersigned understands that postponing the maturity date does not postpone the distribution of any required minimum distribution amounts that may be required under the Federal Internal Revenue Code. I further understand that any such distributions shall fully be the responsibility of the undersigned, and made by written request.

G. Signature Requirements

I certify that I am the IRA or TSA Contract Owner and certify the following:

1. I am the proper party to authorize this distribution and the information provided is true and accurate.
2. All decisions regarding the distribution amount are my own and I expressly assume all responsibility for any consequences arising from these decisions.
3. The IRA Trustee or Custodian has not provided me with any tax advice and I agree that the Trustee or Custodian shall in no way be responsible for any adverse consequences resulting from my decision.
4. If I selected Option 1, 2 or 3 in Section A of this form, I certify that I have read and agree to all sections of this form.
5. I/We understand that by processing this request, I am revoking any existing repetitive payment that may be running on my contract.

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number; 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 Internal Revenue Service (IRS) that I am subject to backup withholding, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (including a U.S. Resident Alien), as defined in the instructions to the IRS Form W-9; and
4. FATCA reporting does not apply to me.

NY RESIDENTS ONLY

Please check one of the following boxes (If none checked we will assume the transaction related to this request was not based on a recommendation).

- The transaction related to this request was not based on a recommendation by my insurance producer.
- The transaction related to this request was based on a recommendation by my insurance producer. I have been informed of the relevant features of this transaction and the potential consequences of this request, both favorable and unfavorable.

Individually Owned:

Print full name of policy/contract owner(s): _____ SSN: _____

Individual Owner's signature: _____ Date: _____

Joint Owner's signature: _____ Date: _____

Trust Owned:

Print full name of trust including date of trust: _____ TIN : _____

Print full name of trustee(s): _____

Trustee(s) signature: _____ Date: _____

Custodian:

Print full name of custodian: _____

Print full name of custodian signor: _____

Custodian signature: _____ Date: _____



Nassau Life and Annuity Company (the Company)
Nassau Life Insurance Company (the Company)
PHL Variable Insurance Company (the Company)
Nassau Life and Annuity Insurance Company (the Company)

Direct Deposit
Quick Reference



Attached is the form you requested. In order for your request to be processed in a timely manner, the **sections referenced below must be completed on the accompanying form.**

Sections A - D
All sections **must** be completed in order for the form to be processed. If you are requesting that your payments be deposited to a **checking** account, please be sure to attach a voided check from that account in the area indicated on the form.

Signatures
Signature requirements are based on the owner designation of the policy/contract. Examples are:

- **Individual:** Print and sign your full name as it appears on the policy/contract.
- **Trust:** The current trustee(s) must sign.
- **Entity:** The current entity must sign.

All signatures must be dated in order to process your request.

Contact Information	US Mail	Shipping / Overnight	Phone	Fax
	PO Box 22012 Albany, NY 12201-2012	15 Tech Valley Dr., Suite 201 East Greenbush, NY 12061-4142	(800) 541-0171	(321) 400-6317



A. Account Information

Policy/Contract Number	Insured/Annuitant Name(s) (Print full name)
Daytime Telephone Number (include area code)	Mobile Telephone Number (include area code)

B. Deposit Account Please note that we do not accept starter checks.

All deposits can only be made to the owner(s) of the contract/policy. A voided check or letter on bank letterhead signed by a bank officer validating your account must accompany this form. Starter checks, handwritten information, and deposit slips will not be accepted. If account cannot be validated, or any requirements are missing, a check will be mailed to your address of record.

Attach Voided Check Here

C. Payee Authorization Statement Your bank may take 1-5 business days to reflect the deposit.

I am entitled to receive payments. I hereby authorize the Company to send all payments due to me by Direct Deposit to the account designated above. This authorization shall be effective until further written notice from me is received by the Company and the Company has had reasonable opportunity to act on it. I expressly acknowledge and understand that any Direct Deposit payments made under this agreement will be strictly an accommodation made to me by the Company, that this authorization revokes all prior payment instruction, and that the Company reserves the right to discontinue or decline to honor this agreement at any time.

Recovery Provisions: To correct any overpayments credited to my account during or after my lifetime, I hereby authorize and direct the bank or other depository on my behalf, on behalf of my estate to debit or charge my account and refund such overpayment to the Company. I also agree such payments will be returned to the Company.

D. Consent

By signing, I authorize insurance companies and bank account verification services to provide information to the Company, its affiliates, service providers or its reinsurers. Any information will be used only for the purpose of risk evaluation, validation of bank account ownership or as required by law.

I authorize the preparation of bank account authentication report. I understand that upon request, I am entitled to receive a copy of the bank account authentication report.

This authorization shall continue to be valid for 30 months from the date it is signed unless otherwise required by law. I understand my authorized representative or I may receive a copy of this authorization on request.

Opt Out

I do not consent. I understand that if I do not give my consent, a direct deposit of my surrender proceeds will not be available and instead a check will be mailed to my address on file with the Company.

Signatures

Individually Owned:

Print full name of policy/contract owner(s): _____ SSN: _____

Individual Owner's signature: _____ Date: _____

Joint Owner's signature: _____ Date: _____

Trust Owned:

Print full name of trust including date of trust: _____ TIN: _____

Print full name of trustee(s): _____

Trustee(s) signature: _____ Date: _____

Entity Owned: (corporate resolution required if not on file)

Print full name of Company: _____ TIN: _____

Print full name and title of authorized signor: _____

Authorized signature: _____ Date: _____



Nassau Life and Annuity Company (the Company)
 Nassau Life Insurance Company (the Company)
 PHL Variable Insurance Company (the Company)
 Nassau Life and Annuity Insurance Company (the Company)

Regular Mail: PO Box 22012, Albany, NY 12201-2012

Overnight Mail: 15 Tech Valley Drive, Suite 201, East Greenbush, NY 12061-4142

**Federal/State Income Tax
 Withholding Election**

Your election will remain in effect until you submit a new Form OL4753 making a new election. You may submit a new Form OL4753 at any time. If you elect not to have withholding apply to your distributions, or if you do not have enough federal income tax withheld from your distributions, you may be responsible for payment of estimated tax.

A. Policy/Contract Information

Policy/Contract Number(s)	Insured(s)/Annuitant(s) Names
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B. Federal Income Tax

Complete the following applicable lines.

I **elect to withhold** at a flat rate of 10% or _____%.

I **elect to withhold** at a flat amount of \$ _____.

I elect **NOT** to have **Federal** income tax withheld.

C. State Income Tax

Complete the following applicable lines.

I **elect to withhold** at a flat rate of _____%.

I **elect to withhold** at a flat amount of \$ _____.

I elect **NOT** to have **State** income tax withheld.

If you reside in one of the following states you must make a state tax withholding election, otherwise we will withhold for state taxes at the rate of 10%:

Arkansas California Connecticut District of Columbia Delaware Georgia Iowa Kansas Massachusetts
 Maine Michigan North Carolina Nebraska Oklahoma Oregon Virginia Vermont

If you reside in one of the following states, we are required to notify you of your right to withhold for state taxes; however, you are not required to make a state tax withholding election. If you do not make an election, we will not withhold for state taxes.

Arizona Indiana Maryland Missouri Montana New Jersey New Mexico
 New York Utah Wisconsin West Virginia

If you reside in a state that is not listed above, you are not required to make a state tax withholding election and you do not need to complete Part C.

D. Taxpayer/Owner Signature

If the Taxpayer is an INDIVIDUAL, complete the following.

Owner Name (Print First, Middle, Last)	Date of Birth (mm/dd/yyyy)	Social Security No./Tax ID	
Street Address (include Apt. or Suite#)	City	State	ZIP Code
Owner Signature	Date (mm/dd/yyyy)		

If the Taxpayer is a NON-INDIVIDUAL, complete the following.

Full Name of Trust, Entity, Corporation or Other	Social Security No./Tax ID		
Signing in the capacity as: <input type="checkbox"/> Trustee <input type="checkbox"/> Partner <input type="checkbox"/> Officer _____ <input type="checkbox"/> Other _____ (List corporate title)			
Name (Print First, Middle, Last)	Signature	Date (mm/dd/yyyy)	
Street Address (include Apt. or Suite#)	City	State	ZIP Code
Name (Print First, Middle, Last)	Signature	Date (mm/dd/yyyy)	
Street Address (include Apt. or Suite#)	City	State	ZIP Code