Policy Cancellation Form

(Term Life, Whole Life, Universal Life, Indexed Universal Life)

☐ COUNTRY Life Insurance Company®
☐ COUNTRY Investors Life Assurance Company®
PO Box 2000, Bloomington, IL 61702-2000
866-COUNTRY (866-268-6879)
countryfinancial.com

- Complete *Section 1* to cancel this Life policy.
- Complete *Section 2* if you need to change any addresses or names associated with this policy only. If requesting only name or address change, submit via Navigator.

Provide all information requested, sign the form, secure witness and spouse signatures if required, and then return the form to Your representative, mail it to the address provided below, or upload through Your on-line COUNTRY account. For questions, please contact your representative or call the Life-Policy Services team at 866-COUNTRY (866-268-6879).

All references to "Company" shall mean COUNTRY Life Insurance Company or COUNTRY Investors Life Assurance Company, as applicable. **All pages of this form must be submitted to the home office for processing.**

Send form to: COUNTRY Life Insurance Company
COUNTRY Investors Life Assurance Company
1701 Towanda Avenue, P.O. Box 2000
Bloomington, IL 61702-2000

Policy number(s): _____

Insured: _____ Policy Owner(s): _____

Section 1: Cancellation details and tax withholding *(a selection must be made)*

If this policy is paid by automatic monthly payment (AMP) or is on a combined billing plan (CBP), we encourage you to call 1-866-COUNTRY (1-866-268-6879) to remove it from your billing plan right away. If your next payment date occurs before we complete your policy cancellation, you will be charged the premium for this policy.

Any proceeds available upon cancellation of this policy should be:

☐ Paid to Policy Owner(s) ***Note:** If check needs to be mailed to an address other than the policy address, please include mailing address in the "Other Instructions" box below.*

OR Applied as an internal replacement or transferred to another policy *(choose one below)*

☐ Unearned premium to be transferred to Policy Number _____
☐ All values to be paid to Policyowner(s)
☐ Partial values to be paid to owner (use unearned premium only) on Policy Number _____

This transaction may cause a taxable event. The Tax Withholding information below must be provided. If you don't provide this information and there is a taxable gain, we will withhold the required amount. Any withholding elections you've previously made will not be valid; you must make a withholding election for each separate transaction. We will withhold any taxable portion if you have not provided a social security number or if we are notified by the IRS that withholding is required.

Federal Withholding

COUNTRY must withhold income tax from any taxable payment made under your contract unless you elect not to have withholding apply. Tax will be withheld on the portion of payment that is considered taxable income.

☐ **Yes, withhold** Federal Income Tax from this payment.
10% will be withheld unless otherwise indicated here: Withhold _____% or $_____(specific amount).

☐ **No, do not withhold** Federal Income Tax from this payment.*

* If you elect not to have Federal Income Tax withheld or the amount withheld is not sufficient, you are liable for Federal Income Tax on the taxable portion of this payment. You also may be subject to tax penalties under the Estimated Tax Payment rules if your payment of estimated tax, and withholding (if any), are not adequate.

State Withholding

Withholding requirements vary by state. Consult your tax advisor for full details.

☐ **Yes, I want to have STATE withholding** on the taxable amount of my distribution.
We will withhold at the rate indicated by the state you reside in. If no rate is designated by your state, please indicate the percentage or the amount you want us to withhold: _____% or $_____.

☐ **No, I do not want to have STATE withholding.**
(Some states require withholding if Federal Withholding is done. If so, this election will be void.)

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Section 2: Name or Address Change *(for policy number(s) listed above only)*: If you need an address change on **all COUNTRY policies**, please contact your representative, log in at COUNTRYFinancial.com or call 866-COUNTRY (866-268-6879).

a. Name Change

Change legal name of: ☐ Owner ☐ Insured ☐ Payor ☐ Other: _____

Former Name *(First)* _____ *(Middle Initial)* _____ *(Last)* _____

New Name *(First)* _____ *(Middle Initial)* _____ *(Last)* _____

Reason for Change: ☐ Correction ☐ Marriage ☐ Divorce ☐ Other: _____

b. Address Change

Change address of: ☐ Owner ☐ Insured ☐ Payor ☐ Other: _____

Name *(First)* _____ *(Middle Initial)* _____ *(Last)* _____

Street Address Line 1: _____

Street Address Line 2: _____

City: _____ State: _____ Zip Code: _____

Phone: _____

c. Secondary Addressee Change

Note: If a secondary addressee is listed on your policy, they will be notified prior to a policy lapse.

☐ Add Secondary Addressee ☐ Delete Secondary Addressee ☐ Update Secondary Address

Name *(First)* _____ *(Middle Initial)* _____ *(Last)* _____

Street Address Line 1: _____

Street Address Line 2: _____

City: _____ State: _____ Zip Code: _____

Phone: _____

**Secondary Addressee's are only available in select states*

Other instructions:

Signatures

Sign below in black ink when using wet signature(s). If your name has changed, please sign with your new name. If you are signing as a fiduciary or representative, you must sign in capacity or with title and provide documentation of your authority. If your policy is assigned, the assignee's signature is required.

In consideration of receipt of the surrender value, I hereby surrender the above-referenced policy or policies. It is agreed that said surrender shall take effect as of the date of the Company's check, at which time all insurance protection shall cease, and that said surrender value is accepted in full settlement and complete satisfaction of all rights, claims, and demands under said policy or policies.

I hereby warrant that the policy identified above is not subject to any assignments, agreements, obligations, legal or court proceedings, orders, liens, or other encumbrances that would prevent or otherwise restrict the surrender requested on this form. I agree to indemnify and hold harmless the Company from any claims, disputes, or losses of any kind that are incurred as a result of this request.

Policy Owner(s) Signature	Date
Witness Signature *(if using wet signature(s)) *If Insurance Representative, include rep number*	Date
Assignee Signature and Title *(if any)*	Date
Other Signature *(if required)*	Date

Spouse signature may be required if you reside in a community property state (AZ, CA, ID, LA, NV, NM, TX, WA, and WI). Please consult a tax or legal professional of your choice to determine whether a spousal signature is required for this form. COUNTRY Life Insurance Company is not responsible for determining whether a spousal signature is required nor in determining the validity of this form under applicable laws.

Spouse Signature	Date