Part (A) Policy Values (Non-Tax Qualified Policies)

To: ◉ State Farm Life Insurance Company ○ State Farm Life and Accident Assurance Company

Re: Policy Numbers _____ Name of Insured _____

☐ **Accumulated Dividend Withdrawal -** Withdraw and pay to me dividend values of $ _____ or the total if less.
☐ **Surrender of Paid-up Dividend Additions -** Withdraw and pay to me dividend values of $ _____ or the total if less.
☐ **Universal Life Partial Withdrawal -** Make a partial withdrawal of $ _____ ($500.00 minimum).
☐ **Policy Loan -** I assign the policy to you as security for this loan and for the interest which will accrue from the effective date of the loan.
  ☐ Make a policy loan of $ _____ or the maximum loan value if less. Add to the loan any premium currently billed and not paid.
  ☐ Make a policy loan to pay the premium currently billed and not paid.
  ☐ Include $ _____ ($15.00 minimum) in each premium billing to be applied as a loan repayment.
  ☐ Include $ _____ ($15.00 minimum) billable loan repayment on Pre-Authorized Collection Plan. *Complete an authorization form.*
☐ **Cash Surrender -** Terminate my policy coverage and pay all cash surrender values to me. Please waive any requirement for surrender of the policy to the Company. I understand my policy cannot be reinstated in the future.

PLEASE NOTE: Any tax reportable gain realized when policy values are released (or transferred to another policy) cannot be changed.

Indicate Payment Method: (Check is the automatic option if no option is selected)

○ Electronic transfer to external bank. Bank Name _____ Account # _____
The account must be enrolled for electronic transfers. If not already enrolled, complete Part F enrollment form and attach voided check for checking account or deposit slip for savings account.

○ Electronic transfer to State Farm Bank. Account # _____ *($100.00 minimum for 1 year Tax Qualified CD)*
If State Farm Bank account is Tax Qualified, please indicate: ○ *Current Tax Year* ○ *Prior Tax Year*

○ Electronic transfer to State Farm Mutual Funds Account # _____ Fund # _____ *($50.00 minimum)*
If State Farm Mutual Funds account is Tax Qualified, please indicate: ○ *Current Tax Year* ○ *Prior Tax Year*

IMPORTANT NOTICE OF WITHHOLDING AND ELECTION Substitute Form W-4P/OMB No 1545-0415 - *(Not applicable in Canada.)*
The taxable portion of proceeds may be subject to federal and state (if applicable) income tax withholding. If we do not have your taxpayer identification number, withholding will occur. By your election, you may be responsible for payment of estimated taxes; and there may be tax penalties if your withholding and estimated payments are not sufficient. **Your withholding election is final and cannot be changed after the transaction is processed.**
Federal Income Tax Withholding - If you have provided your taxpayer identification number, you may elect not to have federal withholding apply by checking the proper box below. **If a box is not checked or if we do not have your taxpayer identification number, federal tax will be withheld at a rate of 10% as required by law.**
○ I do not want federal income tax withheld. ○ Withhold federal income tax at a rate of _____ % (not less than 10%).
○ Withhold federal income tax of $ _____ in addition to the base withholding of 10%.

State Income Tax Withholding - We will only withhold if you live in a state that requires us to withhold. We will withhold at least the minimum amount required by your state. If you would like us to withhold more than the minimum amount, please indicate so below.
○ I do not want state income tax withheld. I understand this election will not apply in states that do not permit persons to elect out of withholding.
○ Withhold my state's minimum required percentage. If you live in a state that does not specify a percentage, we will not withhold.
○ Withhold state taxes according to the following: $ _____. I understand that I cannot request withholding in an amount less than my state's minimum amount.

☐ **Change Mail Address to:** For _____ Policyowner's Telephone Number _____

_____ (Street) _____ (City) _____ (State) _____ (ZIP Code)

☐ **Change Name of:** _____ (Policy Role) **from** _____ (Print Old Name)

to _____ (Print New Name) **due to** _____ (Reason for Change)

The legal name must be provided. If the name of the Policyowner is being changed, sign the new name as "Signature of Policyowner" below.

☐ **Add Successor Owner/Purchaser** _____ (Name of Successor Owner/Purchaser) ☐ **Extend Ownership Control to Age** _____

☐ **Change Ownership to** _____ (New Owner's Name) _____ (New Owner's Signature)

_____ (New Owner's Address) _____ (New Owner's Social Security Number)

ALL OTHER OWNERSHIP PROVISIONS AND RIGHTS WILL REMAIN THE SAME UNLESS SPECIFICALLY CHANGED. If the policy requires endorsement, mailing to the new owner an acknowledgment of the ownership change will serve as the endorsement. **Please Complete W-9 Form.**

☐ **Other** CANCELLATION

Signature of Policyowner _____ Date 7/8/13

Signature of Agent as Witness (Not Required) _____ Date _____

Agent's Code Stamp