PILLAR LIFE INSURANCE COMPANY

TERMINAL ILLNESS BENEFIT WAIVER OF SURRENDER CHARGE CERTIFICATION

This form allows you to notify Pillar Life Insurance of a terminal illness for purposes surrender of charge certification. Please complete part one and have your doctor complete part two.

1. Patient Information

Annuity Contract Number:
Patient Name:
Patient Date of Birth
Patient Social Security Number (last four digits): xxx-xx-____

2. Physician(a) Information:

Your patient is requesting a withdrawal from his/her annuity contract under the terminal illness provision. To assist us in determining the patient's eligibility for these benefits, we require a statement from you. Please review, complete, and sign this form.

The patient named above has a terminal condition as a result of an illness or physical condition that is reasonably expected to result in their death within 12 months.
Date of Diagnosis : _____

Name of Physician:
Degree (MD or DO):
Office Address:_____
Office Phone Number: __(___)_____
License Number: _____

Under penalties of perjury, I certify that:
1. The owner is my patient, and
2. The information provided in this statement is accurate.

Physicians Signature:_____ Date: _____

3. **Return Instructions**

Please return this form to

Pillar Life Insurance Company
711 SW D Ave #100
Lawton, OK 73501

(a) Physician means a licensed M.D. or D.O. acting within the scope of the license. Physician does not include (i) the Contract Owner or the Contract Owner's spouse or (ii) the brother, sister, parent or child of the Contract Owner or of the Contract Owner's spouse.