Inherited IRA Attending Physician Statement

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1. Attending physician statement to be completed by physician (please print)

This form should only be used for an inherited IRA or inherited Roth IRA. The purpose of this form is to help us determine if your patient is eligible for additional payout options on their inherited annuity contract. We need to evaluate the clinical condition of your patient. Please review and provide responses to the applicable questions below.

2. Contract Owner information

Contract number

Patient Name	Patient date of birth (mm/dd/yyyy)

3. Definitions

Physician – A licensed medical doctor (M.D.) or licensed doctor of osteopathy (D.O.) operating within the scope of his or her license, and practicing in the United States. NOTE: The physician cannot be an immediate family member of the patient. Immediate family means the patient's spouse, children, grandchildren, parents, grandparents, siblings, or corresponding in-laws

Disabled – An individual that is unable to engage in substantial gainful activity as of the date of the certification.

Chronically ill – An individual is chronically ill if as of the date of the certification, the individual is unable to perform (without substantial assistance from another individual) at least two (2) activities of daily living for an indefinite period which is reasonably expected to be lengthy in nature (and not merely for 90 days).

4. Certification

Please certify each item below and indicate whether the patent is disabled or chronically ill.

☐ I certify that I am not the Owner or Annuitant on the Contract, or an immediate family member of the patient indicated on this form.

☐ It is my professional medical opinion that, in a manner consistent with accepted standards and practice, the patient is:

☐ Disabled ☐ Chronically ill

☐ It is my professional medical opinion that the Disability or Chronical illness condition will result in death or to be of long-continued and indefinite duration.

CA Residents: For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Physician signature	Date signed (mm/dd/yyyy)

Printed name of physician

Physician address	Physician phone number

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