Inherited IRA attending physician statement

MIDLAND NATIONAL®

CLEAR ALL

P.O. Box 10385, Des Moines, IA 50306-0385

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

This form should only be used for inherited IRA or inherited Roth IRA's. 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. Review and provide responses to the applicable questions below.

2. Contract Owners personal information

Policy/Contract number

Patient name (first, middle initial, last)	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 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 patient 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 chronic illness condition will result in death or to be of long-continued and indefinite duration.

WARNING – Fraud notice: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person, files a statement of claim containing any false or incomplete information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subject such person to criminal and civil penalties as further defined by your state statute.

Signature of physician	Date signed (mm/dd/yyyy)
Physician name (print)	
Physician address	Physician phone number

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