RESET FORM

REQUEST FOR PARTIAL WITHDRAWAL

☐ ReliaStar Life Insurance Company, Minneapolis, MN
☐ ReliaStar Life Insurance Company of New York, Woodbury, NY
☐ Security Life of Denver Insurance Company, Denver, CO
☐ Voya Insurance and Annuity Company, Des Moines, IA
☐ Midwestern United Life Insurance Company, Fort Wayne, IN
A member of the Voya™ family of companies
(the "Company")
Customer Service, 2000 21st Ave. NW, Minot, ND 58703
Fax: 1-877-788-6305 (toll free); Web site: www.voyalifecustomerservice.com

VOYA FINANCIAL™

OWNER INFORMATION *(Please print.)*

Insured Name _____ Policy/File Code Number _____

Owner Name _____ Owner SSN/TIN _____

Owner Address _____ Is this a new address? ☐ Yes ☐ No

City _____ State _____ ZIP _____

Home Phone (_____)_____ Daytime Phone (_____)_____

Please indicate the amount you want to withdraw by checking one of the following:

☐ Partial Withdrawal for $_____ or ☐ Maximum Amount Available

Comments _____

- This request may result in a reduction of the death benefit coverage and cash value of the policy.
- A processing fee, as provided in the policy, will be charged for this partial withdrawal and will be deducted from the remaining cash value of the policy.
- A pro-rata surrender charge may apply, depending on your policy provisions.

It is expressly warranted that no one has any interest in the policy except the undersigned and that no proceedings in insolvency or bankruptcy have been instituted or are pending against the undersigned.

This policy is assigned solely to _____

ERISA PLANS *(If this policy is subject to ERISA, please complete this section.)*

If you are married, your spouse must sign this section, and page 2 if applicable, before a notary public. If you do not complete this section, your signature on page 2 is certification that the policy is not subject to ERISA and/or that you are not married.

The undersigned verify that the payment requested is in accordance with the terms of the plan, applicable law and regulations.

➥ Owner's Spouse Signature _____ Date _____

Employer/Plan Administrator Name _____

➥ Employer/Plan Administrator Signature _____ Date _____

Title _____ Phone (_____)_____

Order #130997 10/29/2014

NOTICE OF WITHHOLDING ON NON-PERIODIC DISTRIBUTIONS OR WITHDRAWALS FROM ANNUITIES, IRA PENSIONS, PROFIT SHARING, LIFE INSURANCE POLICIES, ENDOWMENT CONTRACTS, STOCK BONUSES, AND DEFERRED COMPENSATION PLANS

The distributions or withdrawals you receive from the Company are subject to federal income tax withholding unless you elect not to have withholding apply. Withholding will only apply to the portion of your distribution or withdrawal that is included in your income subject to federal income tax. Thus, for example, there will be no withholding on the return of your own non-deductible contributions to the plan.

You may elect not to have withholding apply to your distribution or withdrawal payments by signing and dating the election and returning it to Customer Service.

ELECTION FOR PAYEES OF NON-PERIODIC PAYMENTS

Please check the appropriate box below, sign and date this form, and return it to Customer Service.

If you do not check a box below, federal income tax will be withheld from the taxable portion of your distribution or withdrawal. Even if you elect not to have federal income tax withheld, you are liable for payment of federal income tax on the taxable portion of your distribution or withdrawal. You also may be subject to tax penalties under the estimated tax payment rules if your payments of estimated tax withholding, if any, are not adequate. If federal income tax is withheld and you reside in a mandatory state, state income tax will also be withheld as required.

☐ **I DO NOT WANT TO HAVE FEDERAL INCOME TAX WITHHELD FROM MY DISTRIBUTION OR WITHDRAWAL.**

☐ **I DO WANT TO HAVE FEDERAL INCOME TAX WITHHELD FROM MY DISTRIBUTION OR WITHDRAWAL.**

CHRONIC ILLNESS ACCELERATED DEATH BENEFIT RIDER NOTICE *(Applicable to policies with the Chronic Illness Rider.)*

By your signature below, you acknowledge that certain changes to your policy or riders may terminate the Chronic Illness Accelerated Death Benefit Rider ("Rider"). For example, loans, partial withdrawals, death benefit option changes, coverage increases and decreases, and benefit payments on any other accelerated death benefit rider under the same policy may terminate Rider benefits. Please refer to the Rider for detailed information and contact your producer with questions about your policy.

US TAXPAYER CERTIFICATIONS

Under penalties of perjury, I certify that:
1. The Taxpayer Identification Number that appears on this form is correct,
2. I am not subject to backup withholding due to failure to report interest and dividend income[1], and
3. I am a U.S. person.

[1] If you are subject to back-up withholding, you must strike through statement number 2.

NON-RESIDENT ALIEN STATUS

If you are a Non-Resident Alien, please check the box below.

☐ Under penalties of perjury, I certify that I am a Non-Resident Alien.

The amount paid to you will be subject to 30% withholding, unless you submit an IRS Form W-8, and are entitled to claim a reduced rate of withholding under the applicable US tax treaty.

SIGNATURES

To avoid a delay in processing, please verify that all required signatures are complete. By signing this form, I acknowledge that the information provided is complete and accurate. If this is a qualified policy, I also acknowledge receipt of the Special Tax Notice and waive the 30-day notice requirement.

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

➥ Owner Signature _____ Date _____

Title [1] _____ Daytime Phone (_____)_____

Owner Address _____

(Please provide full street address for tax purposes.)

City _____ State _____ ZIP _____

➥ Spouse Signature *(if owner lives in community property state)* _____ Date _____

➥ Assignee/Irrevocable Beneficiary Signature *(if applicable)* _____ Date _____

Title [1] _____

➥ Agent Signature *(optional)* _____ Date _____

[1] If owner or assignee is a trust, partnership, or company, officer signature and title is required.

CUSTOMER SERVICE USE ONLY

This request has been filed with the Company and recorded in Customer Service.

New Face Amount _____ By _____ Date _____