

New Business Checklist



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Requirements

- New Business applications/order tickets/request forms, and other required forms, are based on the state in which the application or order ticket is signed.
- All forms **MUST** be completed in their entirety, signed and **dated on or before** the sign date on the application/order ticket/request form. If submitted incorrectly, all **NEW** paperwork will be required.
- All corrections on forms must be crossed out and initialed by the owner. New business forms containing white-out will not be accepted.
- For all transfer cases, please include the transfer company's street address and phone number on the Transfer/Rollover form. Please include an estimated transfer amount on the application.
- If additional purchase payments will be made after the contract is established, please complete all required new business and replacement forms based on the client's **resident state**.
- If a separate beneficiary sheet will be submitted, it must be dated and signed by the owner (Beneficiary Designation Form X2614105NW).
- For applications/order tickets/request forms involving a Trust, please have the applicable representative sign a Trust Certification and Agreement (Form #X6017907NW). This form is required for all sales that involve a change of ownership or beneficiary to a Trust, as well as all new sales that involve a Trust.
- If a Power of Attorney is being used, please submit a complete copy of the POA document along with a certified/notarized Affidavit Related to Power of Attorney (Form #AAG2816).
- If the new contract is funded with tax qualified funds, and the owner is over age 70½, then the required minimum distribution (RMD) **must** be satisfied **prior to funds being transferred**.
- If the Easy Systematic Program (ESP) for Customized Payment Options is requested, the owner must complete the appropriate systematic withdrawal request form. Please note that some ESP options are not available in the first year. Please refer to the applicable Product Guide for availability of options.
- At Great American Financial Resources®, we want your paperwork for New Business to be hassle-free. Comprehensive disclosure forms that include information about Client Understanding, Anti-Money Laundering and Client Suitability must be signed by your clients at point of sale. Please note that the Great American Life® Long-Term Care annuity will still require the Client Letter of Understanding and other required disclosure forms.
- Review the New Business Kit for all applicable forms required by your state.

For any further questions, please contact a Inside Wholesaler at (800) 438.3398, ext. 17197.

Great American Financial Resources®, Inc.
P.O. Box 5420
Cincinnati, OH 45201-5420

Overnight Address:
Great American Financial Resources®, Inc.
525 Vine Street
14th Floor Attn: New Business
Cincinnati, Ohio 45202

Annuity Investors Life Insurance Company®

Great American life Insurance Company®

Administrative Address: P.O. Box 5420, Cincinnati, Ohio 45201-5420



Group Fixed Annuity Enrollment Form

1. Participant

Name _____
 Address _____
 City _____ State _____ Zip _____
 Phone _____ Sex M F
 SSN _____ Birth date _____

2. Employer Information

Name _____
 Address _____
 City _____ State _____ Zip _____
 Phone _____
 Tax ID # _____

3. Beneficiary (P-Primary, C-Contingent)

If the beneficiary listed below is not designated as a Primary or Contingent beneficiary, it will automatically default to a Primary designation. All shares will be divided equally unless otherwise noted in the space provided.

List additional beneficiaries on a separate page signed by Owner and dated the same date as this Enrollment Form. Share/Percentage must equal 100%. If beneficiary is a trust, list the name of the trust, name(s) of the current trustee(s), and trust agreement date AND provide copies of the first and signature pages of the trust.

P C Share/Percentage _____ %
 Name _____
 Address _____
 City _____ State _____ Zip _____
 SSN _____ Relationship _____

P C Share/Percentage _____ %
 Name _____
 Address _____
 City _____ State _____ Zip _____
 SSN _____ Relationship _____

P C Share/Percentage _____ %
 Name _____
 Address _____
 City _____ State _____ Zip _____
 SSN _____ Relationship _____

P C Share/Percentage _____ %
 Name _____
 Address _____
 City _____ State _____ Zip _____
 SSN _____ Relationship _____

4. Contract Information

A. Product Name _____

B. Type of Group
 Employer Other _____

C. Purchase Payment(s)
 Employer/Salary Reduction (TSA)
 Bank draft (monthly only)
 (For savings/checking account deductions, please complete and attach the required forms)
 Other _____
 Initial Purchase Payment: Amount \$ _____
 Check enclosed (check here if indirect rollover)
 Transfer/Rollover/1035 Exchange (attach required forms)
 Periodic purchase payments (attach required forms)

4. Contract Information (Continued)

D. Subsequent Purchase Payments:

For Salary Reduction Only (Circle Non-Billing Months)

Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec

First Salary Reduction Date _____

Frequency

Weekly Bi-Weekly Twice Monthly

Monthly Quarterly Annually

Ten Payments

Other _____

Total Annual Purchase Payments \$ _____ Per Year

E. Tax Qualification for New Annuity

TSA 403(b)

457

Pension/Profit Sharing (401(a))

401(k)

Other (please specify) _____

F. Source of Tax Qualified Contributions

Employer

Employee

Both

G. Special Requests

5. Notices (Please review the notice that applies to your state.)

ALL STATES:

Patriot Act Notice

To help the government fight the funding of terrorism and money laundering activities, Federal law requires us to obtain all relevant customer-related information necessary to run an effective anti-money laundering program.

What this means to you: When submitting an enrollment form, we ask that the producer obtain the client's name, street address, date of birth, tax identification number and other customer-related information that will allow us to identify the customer and fulfill our obligations under Federal law. Picture documentation, such as a driver's license or other identifying documents, will be used to verify the information given at the time of the sale.

Arizona Residents: Upon written request, we will provide factual information within a reasonable time regarding the benefits and provisions of the Contract. If for any reason you are not satisfied, you may return it within ten (10) days or within 30 days if the contract holder is age 65 or older on the date of the application for the annuity contract, after the Contract is delivered to you and receive a refund of all monies paid.

Arkansas, Louisiana and New Mexico Residents:

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an enrollment form for insurance is guilty of a crime and may be subject to civil and criminal penalties.

Colorado Residents: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of insurance within the Department of Regulatory Agencies.

District of Columbia Residents: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment, and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Hawaii Residents: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

5. Notices (Please review the notice that applies to your state.) (Continued)

Kentucky and Pennsylvania Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an enrollment form for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Maine, Tennessee, Virginia and Washington Residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or a denial of insurance benefits.

Maryland Residents: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an enrollment form for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Maryland Residents: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an enrollment form for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey Residents: Any person who includes any false or misleading information on an enrollment form for an insurance policy is subject to criminal and civil penalties.

Ohio Residents: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an enrollment form or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma Residents: WARNING: Any person who knowingly and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

6. Existing Insurance/Replacement

A. If you live in [AL, AK, AZ, CO, HI, IA, KY, LA, ME, MD, MS, MT, NE, NH, NJ, NM, NC, OH, OR, RI, TX, UT, VT, VA or WV], answer question # 1.

1. Do you have any existing life insurance policies or individual annuity contracts currently in force with this Company or any other company? Yes No

If "Yes" to # 1, complete the Notice Regarding Replacements of Life and Annuities. Your agent must present and read the Notice to you unless you voluntarily waive this step.

B. If you live in [AR, CA, CT, DE, DC, FL, GA, ID, IL, IN, KS, MA, MI, MN, MO, NV, ND, OK, PA, SC, SD, TN, WA, WI or WY], answer only question # 2.

2. Will this contract replace or use cash values of any existing life insurance or annuity with this company or any other company? Yes No

If "Yes" to # 2, please provide company name and policy/contract #.

Company _____
Policy/Contract # _____

7. Verification of Client Identification

A. Owner

Drivers License/ State/Country: _____
 State ID Number: _____

Passport Date Issued: _____

Other (photo id) Exp. Date _____

Owner is an entity, legal document(s) attached (e.g. Articles of Incorporation, Trust Agreement, etc.)

Occupation: _____

Employer: _____

Retired Yes No

B. The source of funds for this transaction is: _____

The purpose of this transaction : _____

8. Agreement

By signing this form, I understand and agree to all of the following:
 All statements and answers on this form are made to secure the Certificate for which this form is submitted. I understand that the Company issuing the Certificate is not responsible for tax and legal aspects or proper administration of, or for providing administrative or other services to, the Employer's plan or trust. I have read this form and I understand each of the statements and answers on this form. I represent that the information contained in this enrollment form is true and complete to the best of my knowledge and belief. I received a Disclosure Document that includes information about my annuity contract, its benefits, and the fees and charges that apply to it.

Joint Owner

Drivers License/ State/Country: _____
 State ID Number: _____

Passport Date Issued: _____

Other (photo id) Exp. Date: _____

Occupation: _____

Employer: _____

Retired Yes No

By signing below, I/we also authorize(s) any law enforcement agency, public or private institution, information service bureau or other entity contacted by the Company to furnish information sufficient to confirm my/our personal information as required by Federal law. I/we hereby release(s) all persons, agents and agencies, and entities providing confirming information from any and all liability arising out of the request for or the release of confirming information

Signed at (city) _____ **(state)** _____

Owner's Signature _____

Date _____

Joint Owner/Plan Administrator's Signature *(if applicable)*

Date _____

9. Agent's Statement

To the best of my knowledge and belief, (1) the purchaser(s) **does** **does not** have any existing life insurance policies or annuity contracts currently in force with this or any other company; and (2) the annuity being purchased **is** **is not** intended to replace or use cash values of any existing life insurance or annuity with this or any other company. If the purchaser(s) does have existing life insurance policies or annuity contracts, please read the appropriate replacement forms to the purchaser(s) (unless voluntarily waived) and complete the appropriate replacement forms. If the annuity being purchased is intended to replace or use cash values of any existing life insurance or annuity with this or any other company, please complete the appropriate replacement forms.

If the Contract applied for replaces any existing life insurance or annuity with this or any other company, I attest that I have reviewed the potential advantages and disadvantages of the proposed transaction.

I hereby certify that in connection with my presentation to the purchaser(s) herein, I only used sales material that was previously approved by the Company and that I left with the Applicant(s) a copy of all sales material used in my presentation. (**"Sales Material means a sales illustration and other written, printed or electronically presented information created, completed or provided by the Company or the Agent and is used in the presentation to the Applicant in connection with the contract purchased).**

I further certify that this transaction is in accord with the Company's written statement with respect to the acceptability and appropriateness of replacements.

1st Agent's Name (please print) _____

Agent's Signature _____

Date _____

Agent Code # _____ **Commission Split** 100 %

Phone _____

E-Mail Address _____

2nd Agent's Name (please print) _____

Agent's Signature _____

Date _____

Agent Code # _____ **Commission Split** _____ %

Phone _____

E-Mail Address _____

10. For MGA/Agent Use Only (Commission Structure Codes)

Great Flex Group NT T1 T2

Default is T1

Product Disclosure – To be retained by the participant

Thank you for purchasing this certificate under a master group annuity contract offered through Annuity Investors Life Insurance Company. This annuity is designed for the long-term accumulation of funds for future needs and/or retirement. The master group annuity contract and your certificate are qualified, and their particular status is determined by the tax qualification endorsement attached to them. Here are some of the facts about the **GreatFlex Group** annuity:

INTEREST RATE DISCLOSURE

Interest Rate: The company will credit interest beginning with the issue date of your certificate. Each Purchase Payment will receive the interest rate in effect on the date it is applied to the contract, and it is guaranteed for one year. After that, the applicable interest rate will be the rate the company declares from time to time. Contact your agent or Annuity Investors® Life for current rate information.

Guaranteed Minimum Interest Rate: Your certificate, as a whole, will be credited with interest at an effective annual rate equal to or greater than that required by state law. Contact your agent for the guaranteed minimum rate applicable in your state.

GENERAL DISCLOSURES

Early Withdrawal Charge: An early withdrawal charge applies to any amount withdrawn within five years of the group Contract Effective Date. The early withdrawal charge will be calculated according to the following schedule:

Certificate Year:	1	2	3	4	5	6+
Early Withdrawal Charge:	5%	4%	3%	2%	1%	0%

Early withdrawal charges will apply to withdrawals in excess of the Free Withdrawal Allowance, a full surrender or an annuitization with a payout period of less than seven years. This charge does not apply after the fifth contract anniversary on the group master contract.

Free Withdrawal Allowance: During the first certificate year, you may withdraw credited interest from your certificate without deduction of an early withdrawal charge. At any time after the first certificate year, you may withdraw up to 10% of the prior certificate anniversary's Account Value without deduction of an early withdrawal charge. The sum of all previous withdrawals during the same certificate year will be subtracted to determine the amount available. This free withdrawal allowance is not cumulative, and unused amounts do not carry over to the next certificate year.

Waiver on Severing Employment: No early withdrawal charge will apply if you have severed employment with the employer that owns the master group annuity contract or that sponsors the retirement plan to which it relates.

Loans: To the extent permitted by your employer plan, 403(b) TSA, Governmental 457 and 401 Pension/Profit Sharing certificates allow loans subject to the terms set out in the loan endorsement (E1605804NW). Loans may adversely affect certificate values. On default, the loan balance may be treated as a taxable distribution to you. The loan balances may be deducted from certificate values on a default, surrender or annuitization.

Annuitization: The Account Value will be used to provide income benefit payments if payments are to be made for life or over a period of at least seven years. Otherwise the Surrender Value will be used to provide income payments. *Annuitization options include: Income for a Fixed Period; Life Annuity with Payments for at Least a Fixed Period; Joint and One-Half Survivor; and any other form accepted by the company.*

Death Benefit: A death benefit equal to the Account Value is generally payable upon the participant's death before annuitization. A spouse who is the sole beneficiary may succeed to the ownership of the participant's interest in the contract in lieu of taking the death benefit.

Replacements: If this annuity is replacing an existing annuity, it is important that you compare the benefits, features and costs of the two annuities. You should consider any surrender charges you may incur on the surrender of the existing annuity and your need to access your money. For information about your existing annuity, contact the issuing company.

Commission Payment: The company will pay your agent a commission as a result of your purchase of an interest in this annuity product.

Taxation: Except to the extent that distributions represent a return of after-tax contributions, all distributions are generally subject to taxation at the time of receipt, and distributions prior to age 59½ may be subject to a penalty tax. Additionally, distributions from certain qualified certificates may be restricted as required by tax law or an employer plan. Note that qualified plans provide tax deferral and that using an annuity to fund a qualified plan provides no additional tax deferral. Therefore, an annuity should be used for other benefits.

- Annuity Investors Life Insurance Company®
- Great American Life Insurance Company®
- Loyal American Life Insurance Company®

IMPORTANT NOTICE

Replacement of Life Insurance or Annuities

This document must be signed by the applicant and the producer, if there is one, and a copy left with the applicant.

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy, to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interest. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on the back of this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? Yes No
2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? Yes No

If you answered "Yes" to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured or annuitant, and the contract or policy number if available) and whether each contract or policy will be replaced or used as a source of financing:

Insurer Name	Contract or Policy #	Insured or Annuitant	Replaced (R) or Financing (F)
1.			
2.			
3.			

Make sure you know the facts. Contact your existing company or its agents for information about the old policy or contract. If you request one, an in-force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer. Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

The existing policy or contract is being replaced because _____
 I certify that the responses herein are, to the best of my knowledge, accurate:

 Applicant's Signature and Printed Name Date

 Agent's/Producer's Signature and Agent's/Producer's Printed Name Date

I do not want this notice read aloud to me. _____ (Applicants must initial only if they do not want the notice read aloud.)

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or agent that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense:

PREMIUMS :

Are they affordable?

Could they change?

You're older—are premiums higher for the proposed new policy?

How long will you have to pay premiums on the new policy? On the old policy?

POLICY VALUES :

New policies usually take longer to build cash values and to pay dividends.

Acquisition costs for the old policy may have been paid; you will incur costs for the new one.

What surrender charges do the policies have?

What expense and sales charges will you pay on the new policy?

Does the new policy provide more insurance coverage?

INSURABILITY :

If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down.

You may need a medical exam for a new policy.

Claims on most new policies for up to the first two years can be denied based on inaccurate statements.

Suicide limitations may begin anew on the new coverage.

IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY :

How are premiums for both policies being paid?

How will the premiums on your existing policy be affected?

Will a loan be deducted from death benefits?

What values from the old policy are being used to pay premiums?

IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST SENSITIVE LIFE PRODUCT :

Will you pay surrender charges on your old contract?

What are the interest rate guarantees for the new contract?

Have you compared the contract charges or other policy expenses?

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS :

What are the tax consequences of buying the new policy?

Is this a tax-free exchange? (See your tax advisor.)

Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code?

Will the existing insurer be willing to modify the old policy?

How does the quality and financial stability of the new company compare with your existing company?



GREAT AMERICAN LIFE INSURANCE COMPANY®
ANNUITY INVESTORS LIFE INSURANCE COMPANY®
LOYAL AMERICAN LIFE INSURANCE COMPANY®

FINANCIAL RESOURCES

If Needed

ADDITIONAL BENEFICIARY DESIGNATION FORM

(When used, this Form MUST be accompanied by an Application/Order Ticket/Request Form.)

1. BENEFICIARY ELECTION (Please print)

The Death Benefit will be paid to the primary beneficiaries or survivors of them in equal shares unless otherwise stated. The Death Benefit will be paid to contingent beneficiaries or survivors of them in equal shares only if there are no surviving primary beneficiaries. If additional space is needed, please attach a separate page signed by the owner(s) and dated the same date as this application/order ticket/request form.

Please show full name, address, relationship to Owner(s), and Social Security Number/Tax ID Number of all beneficiaries. If the Beneficiary is a trust, please list the name of the trust, the name(s) of the current trustee(s), and the trust agreement date AND provide copies of the first and signature pages of the trust.

PRIMARY BENEFICIARY(IES):

Name	Address	SSN/Tax ID #	Relationship to Owner

CONTINGENT BENEFICIARY(IES):

Name	Address	SSN/Tax ID #	Relationship to Owner

2. SIGNATURE AUTHORIZATION

_____ Name of Owner (Please print)	_____ Signature of Owner	_____ Date
_____ Name of Joint Owner (If applicable - Please print)	_____ Signature of Joint Owner (If Applicable)	_____ Date



SALARY REDUCTION AGREEMENT

For GAFRI Company:

- Great American Life Insurance Company
Annuity Investors Life Insurance Company

1. EMPLOYER INFORMATION

Employer Name _____

- Plan: Section 403(b) Tax-Sheltered Annuity Program
Section 457 Deferred Compensation Plan
Section 401(k) Cash or Deferred Arrangement

2. SALARY REDUCTION INFORMATION

Subject to the annual contribution limits and other requirements of the Plan, I authorize the Employer to reduce my cash compensation in exchange for the prompt payment of equal amount to the Great American Financial Resources, Inc. company indicated above for deposit to a qualified annuity as a salary reduction contribution under the Plan. The amount of such reduction and payment shall be as follows:

% of my gross cash compensation
OR
\$ for number of pay periods
OR
\$ annual payment

To the extent permitted by the Plan, my salary reduction election may include a catch-up contribution amount in excess of the normal contribution limits because by the end of the calendar year in which this election takes effect:

- I will be age 50 or older;
I will have completed 15 years of service with the Employer (TSA Programs only); and/or
I will not yet be normal retirement age, but will reach it in one of the next three calendar years (457 Plans only).

To the extent permitted by the Plan, I elect that % (from 0% up to 100%) of my contributions be made as after-tax Roth 403(b)/401(k) contributions. (If you don't complete this option, all of your contributions will be made on a pre-tax basis.)

3. EFFECTIVE DATE

This Salary Reduction Agreement shall take effect as soon as permitted under the Plan and as soon as administratively feasible or, if later, _____, 20_____.

Please discontinue remittance to _____ as of this effective date. (company name)

4. DURATION

This Salary Reduction Agreement replaces any earlier Salary Reduction Agreement I have made under the Plan and shall be legally binding and irrevocable with respect to amounts earned while it is in effect. This Salary Reduction Agreement will remain in effect as long as I remain an eligible employee under the Plan or until I provide the Employer with a written request to end my salary reduction contributions or submit a new Salary Reduction Agreement, as permitted under the Plan.

Employee Signature Employee Name (Printed) Social Security Number

Agent/Representative Name (printed) Date

For Employer Use Only

Date Received By

Date Effective

Transfer/Exchange Request for Non-Qualified Funds

N / AN / A



- Great American Life, Annuity Investors Life Annuities Fixed Annuity, Loyal American Life, Annuity Investors Life Annuities Variable Annuity

1. Current account information

Owner name, Social Security/tax ID #, Joint owner name, Social Security/tax ID #, Annuitant/insured/participant, Social Security/tax ID #, Joint annuitant name, Social Security/tax ID #

Policy/contract (required; select one), Existing company/insurer/bank name, Company address, City/state/zip, Company phone, Account number(s)

2. Non-qualified account information

1035 Exchange (non-qualified annuity/life insurance), Other non-qualified transfer from: CD, Stock, Other, Full, Partial

I agree to pay any premium on the prior policy required before the date it is surrendered, and assume full responsibility for any lapse of the prior policy for nonpayment of premiums or otherwise.

Transfer these funds: Immediately, On, To: New policy, Policy in force

I understand and agree that the value of my account listed above will not be credited to my annuity with the GAFRI company until the funds are received by the GAFRI company in cash...

Owner signature (required), Joint owner signature (if applicable), Annuitant signature (required), Joint annuitant signature (if applicable), Witness signature (Agent), Guarantee signature (if required)

3. Information for 1035 Exchange from prior carrier (List cost basis information for contract being exchanged.)

Pre-TEFRA Deposits on/before 8/13/82 (net of withdrawals) \$

Post-TEFRA Deposits on/after 8/14/82 (net of withdrawals) \$

Were any deposits made after 6/30/86? Yes No

Institution representative name (print), Institution representative signature, Date

4. Acceptance (completed by Home Office)

The GAFRI company accepts this transfer or rollover and requests that the amount to be transferred or rolled over be liquidated and forwarded to it.

Authorized signature, Title, Ext., Date, Officer signature, Executive Vice President, Title

Make check(s) payable to: Annuity Investors Life Insurance Co., Great American Life Insurance Co., Loyal American Life Insurance Co., FBO, Contract #, P.O. Box 5420, Cincinnati, OH 45201-5420, (800) 854.3649

For overnight: 525 Vine Street • Cincinnati, OH 45202



Great American Plan AdministratorsSM, Inc.
P.O. Box 60
Cincinnati, OH 45201-0060
(800) 695-1471 (Toll Free)
(513) 412-8645 (Local)
(513) 357-3199 (Fax)
www.gaplandata.com

Contribution Allocation Form

1. Employee Information

Name Telephone #
Mailing Address D.O.B.
City State Zip Social Security No.
Date of Hire E-Mail Address

2. Employer Information

Employer Name Telephone #
Mailing Address
City State Zip

- Plan Type:
403(b) TSA
Roth 403(b)
Governmental 457 Plan
401(k) or 401(a) Plan
Roth 401(k) Plan
Other

3. Allocation Directive

Part A. Effective for contributions received by Great American Plan Administrators, Inc. on or after:

(MM/DD/YYYY)

Part B. Expected contribution amount per billing cycle:

\$ Employee \$ Employer

Part C. Allocation Instructions: Please indicate the company name of the product issuer, and whether the contributions should be allocated as a fixed dollar amount or on a percentage basis. Allocations based on fixed dollar amounts will be satisfied in the order listed below with 100% of any funds remaining allocated to the last account listed.

Company Name	Product Type	Account Number	Fixed Amount	Percentage
1.			\$	%
2.			\$	%
3.			\$	%
4.			\$	%
5.			\$	%

4. Authorization Agreement

I hereby authorize and direct Great American Plan AdministratorsSM, Inc., either directly or through a third party* (hereinafter referred to as the "Remitter"), to remit contributions to the insurance, financial and/or investment institutions listed above in the amount/percentages listed above. These contributions will be forwarded by my employer to the Remitter pursuant to the directions provided by me above in accordance with procedures established by my employer.

I hereby agree to and acknowledge the following:

I am permitted to modify the above listed amounts/percentages which are remitted to each insurance, financial/or investment institution, and such modification may only be affected by my completing and forwarding to the Remitter a new Contribution Allocation Form. Any modification I make may be subject to limitation by rules or regulations of the insurance, financial and/or investment institutions and I accept all responsibility for compliance with, and all responsibility or liability for noncompliance with, any such rules or regulations and hereby release and hold harmless the Remitter from any claims or liability which may arise as a result of my non-compliance with such rules or regulations. Such changes will be made as soon as practicable upon receipt by the Remitter, and the Remitter assumes no responsibility for damages arising out of any delay in implementing these changes so long as the Remitter has operated in a reasonable manner.

Employee Signature: _____ **Date:** _____

To Be Completed by Sales Representative

I agree to comply with all pertinent written directives regarding the allocation requests of Employees.

Sales Representative Name: _____ **Phone:** (_____) _____

Signature: _____ **Date:** _____

* *In certain situations, common remitting services are provided by Great American Advisors[®], Inc., DBA GALIC Disbursing Company[®]. Great American Advisors, Inc., a registered broker/dealer and Member NASD, is located at 525 Vine Street, 7th Floor, Cincinnati, OH 45202.*

For GA Plan Administrators Use Only	
Date Received: _____	
Date Effective: _____	Initials: _____