REQUEST FOR WITHDRAWAL UNDER TERMINAL ILLNESS/CONFINEMENT WAIVER

ATHENE®

Athene Annuity and Life Company
Athene Annuity & Life Assurance Company
Home Office West Des Moines IA 50266

Athene Life Insurance Company of New York
Athene Annuity & Life Assurance Company of New York
Home Office Pearl River NY 10965

Owner/Annuitant's Statement Any person, who knowingly and with intent to deceive or defraud, files a claim containing false, incomplete or misleading information, may be in violation of state law. Use of mail to defraud is a violation of federal law.

In order to qualify for this benefit, please confirm the Annuitant meets the following requirements:

1. The annuitant is at least 50 years of age: ☐ Yes ☐ No
2. The annuity contract has been in force for at least one year (State of Kansas is 2 years): ☐ Yes ☐ No

If the answer to either of these questions is no, the annuitant does not qualify for the benefit.

To help ensure prompt processing of your claim, please make sure all forms are complete.

1) Name:	2) Date of Birth:	3) Social Security Number:	4) Are you a resident of the United State? ☐ Yes ☐ No
5) Owner/Annuitant's address:		6) List contract numbers for all Athene contracts owned by theOwner/Annuitant:	
7) Name and address of physician: Phone Number: (_____) _____		8) Is the condition a result of: A.Illness: ☐ Yes ☐ No B. Accident: ☐ Yes ☐ No If yes, to either, please provide details:	
9) What Type of facility is providing yourcare? ☐ Long Term Care Facility ☐ Skilled Nursing Facility ☐ Intermediate Nursing Facility ☐ Hospital		10) Name and address of facility: Phone Number: (_____) _____	
11) Date patient entered the care facility: _____			

I authorize any physician, hospital, clinic, insurance company, or any other organization, that has any records or knowledge of my health and disability to give Athene that information. A photocopy of this authorization shall be as valid as the original.

Fraud Warning Statement For New York residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Owner Signature X	Owner's Title (if corporation or trust)	Date (mm/dd/yyyy) / /
Joint Owner Signature X	Print Name	Date (mm/dd/yyyy) / /

If you are signing on behalf of the owner, please print your name and provide your signature below. Check the box that applies to the capacity in which you are signing. If you have not already done so, please provide your Power of Attorney, Conservatorship, or Guardianship documents to verify you are authorized to act on behalf of the owner.

☐ Conservator ☐ Guardian ☐ Power of Attorney

Signature X	Print Name	Date (mm/dd/yyyy) / /

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Important: This is part of the request form. Please review the applicable fraud notice for your state below.

All states (except as noted below): Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Residents of AK: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Residents of AL: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison or any combination thereof.

Residents of AZ: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Residents of CA: For your protection, California law requires the following statement 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.

Residents of CO: 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 producer 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 settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Residents of DC: 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 application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Residents of DE, ID, IN, OK: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony.

Residents of FL: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Residents of KY: Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

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

Residents of ME, TN, VA, WA: 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.

Residents of MN: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

Residents of NH: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in N.H. Rev. Stat. Ann. §638:20.
subject to criminal and civil penalties.

Residents of NM: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

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

Residents of OR: Any person who knowingly presents a materially false or fraudulent claim for payment of a loss or benefit, or knowingly presents materially false information in an application for insurance, may be guilty of a crime and may be subject to fines and confinement in prison, depending on state law.

Residents of PA: Any person who knowingly and with intent to defraud any insurance company or other person files an application 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.

Residents of PR: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss of any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and , upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand ($5,000) dollars and not more than ten thousand ($10,000) dollars, or a fixed term of imprisonment for three (3) years, or both penalties. If aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years. If extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

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

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

ATTENDING PHYSICIAN'S STATEMENT

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This form may not be completed by a physician who is a member of the patient's family or who is an employee of the facility in which the patient is/was confined.

Patient's Name:	Patient's Date of Birth:

1. Diagnosis or nature of illness or injury that requiredconfinement: _____
2. Date you were first consulted for the patient'scondition: _____
3. Has the patient previously been treated for the same or similar symptoms? ☐ Yes ☐ No
4. Date the patient was admitted for long term care: _____
5. Does the patient need continual supervision due to deterioration or loss of intellectual capacity? ☐ Yes ☐ No
6. Prognosis: Indicate the patient's life expectancy *(check one)*:
   ☐ 1 month ☐ 1 – 3 months ☐ 3 – 6 months ☐ 6 – 12 months ☐ Longer than 24 months

Physician's Remarks:

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

Signature of Physician	Date (mm/dd/yyyy) / /
Print Name	Medical License Number
Office Street Address	
City, State, and Zip Code	

CONFINEMENT or TERMINAL ILLNESS
Facility or Provider of Care Services Form

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1. CONTRACT INFORMATION

Contract Number	Name of Patient/Designated Annuitant		
Name of Contract Owner	Social Security Number		
Mailing Address	City	State	Zip
Name of Joint Owner (if applicable)			

2. AUTHORIZATION TO RELEASE INFORMATION – To be completed by the designated annuitant or person acting on his/her behalf:

Name of Facility or Care Services Provider:_____

Address of Facility or Care Services Provider:_____

Phone Number of Facility or Care Services Provider: _____

I authorize the Facility or Care Services Provider, as named above, to release information relevant to my confinement and/or care, and to provide such information to Athene, or its representative.

Signature of Patient/Designated Annuitant	Date (mm/dd/yyyy) / /

3. THIS SECTION SHOULD BE COMPLETED BY A REPRESENTATIVE OF THE FACILITY OR CARE SERVICES PROVIDER

1. Date on which patient's confinement, or care, began. _____/_____/_____
2. Date on which patient's confinement or care ceased (if applicable). _____/_____/_____
3. Was the confinement or care continuous? ☐ Yes ☐ No
4. Briefly describe the services provided to this patient: _____

   _____
5. Briefly describe the facility, if patient is confined: _____

   _____

   _____
6. Under what type of license does the Facility or Care Services Provider operate? _____

   _____

PLEASE RETURN A COPY OF CURRENT LICENSE(S) OFTHE FACILITY OR CARE SERVICES PROVIDER WITH THIS FORM.

4. YOUR CONFIRMATION

Facility Name (Please Print)			State License Number
Facility Street Address			
City	State	Zip	Office Telephone Number
Authorized Signature X			Date (mm/dd/yyyy) / /
Print Name	Job Title		

Athene will not be responsible for payment of any fees associated with the completion of this form.