BENEFIT 10 - Request for Withdrawal under Terminal Illness or Confinement Provision - Enhanced Benefit Rider

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

Use this form to elect payments under the Terminal Illness or Confinement Benefit Provision of the Enhanced Benefits Rider. Upon Athene's approval, payments equal to 20% of the benefit base as of the date of approval will be paid to you annually. All other systematic withdrawals will be discontinued.

To qualify for this benefit, the following requirements must be met.

- The annuitant must be a resident of the United States on the date of approval
- The annuitant is at least 50 years of age
- The annuitant has been confined for 180 consecutive days (for Confinement Benefit only)

1. INFORMATION ABOUT THE OWNER

Individual, Trustee or Company Name				
If Trust, list Trust Name and Trust Date		Email Address		
Contract Number(s)		☐ Address Change Requested*		
Mailing Address	City	State	Zip	Country
Street Address (**REQUIRED** if mailing address is a PO Box)	City	State	Zip	Country
Social Security Number / TIN	Date of Birth (mm/dd/yyyy) / /	Personal Phone ( ) -		

*For your protection, confirmation of your address change will be sent to you.

2. SELECT YOUR BENEFIT PROVISION

☐ TERMINAL ILLNESS PROVISION - Please have your physician complete and return the Attending Physician's Statement found on page 4.

☐ CONFINEMENT BENEFIT PROVISION - Please complete the following information below, have your physician complete and return the Attending Physician's statement, and have the care facility complete and return the Facility Statement found on page 5.

1. Your confinement is due to: ☐ Illness ☐ Injury. Please describe below.

_____

_____

2. What type of facility is providing your care?
   - ☐ Intermediate Nursing Facility
   - ☐ Skilled Nursing Facility
   - ☐ Hospital
3. Date you entered the facility? _____

3. DISTRIBUTION ELECTIONS

Enter the date you want payments to begin. / / (mm/dd/yyyy)

How do you want to receive the payments? ☐ Check ☐ EFT - Please complete Section 5.

4. YOUR TAX WITHHOLDING ELECTION

Federal income tax withholding instructions (select one option only):
The withdrawals you receive from your annuity contract are subject to 10% federal income tax withholding. You may elect to not have withholding apply. Withholding will only apply to the portion of your withdrawal included in your income subject to federal income tax. If you choose to withhold federal income tax, we may also be required to withhold state income tax. If you DO NOT make a withholding election, 10% federal income tax with the applicable state income tax will be withheld as appropriate.

☐ Do not withhold federal or state income tax from my payments.

☐ Withhold federal income tax at the default rate of 10%.

☐ Withhold federal income tax based upon the enclosed W-4R. To elect a different rate of withholding other than the 10%, the IRS requires you submit from W-4R, Withholding Certificate of Nonperiodic Payments and Eligible Rollover Distribution. You can access this form on the IRS.gov website.

State income tax withholding instructions (select one option only):
Depending on the type of withdrawal you receive, some states require a state specific form to opt out of withholding. If you do not provide this state specific form, make an election or if your state requires a greater amount of state withholding than what has been elected below, we will withhold at the rate specified by your state of residence on file until the required state specific form is received by our office. If state withholding is elected and no percentage is specified, we will default to 5% or the mandatory percentage required in your state.

☐ Do not withold state income tax from my payments.

☐ Withhold _____$ or $_____ state income tax from my payment.

NOTE: If you elect to not have withholding apply to your withdrawal or if you do not have enough federal income tax withheld, you may be responsible for payment of estimated tax. You may incur penalties under the estimated tax rules if your withholding and estimated tax payments are not sufficient. We recommend you consult your personal tax advisor regarding your specific tax situation.

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5. YOUR DIRECT DEPOSIT

For Athene to deposit money directly in your bank account using electronic funds transfer (EFT), please provide your banking information below. Athene will perform bank account validation using third party software and if approved, Athene will utilize the banking information provided for this request and all future disbursements until Athene receives written notification to terminate or suspend the banking information. Athene may contact your financial institution to verify information regarding the banking information and to resolve any problems related to electronic deposits or errors in deposit. The date of the disbursement is when the funds are removed from your contract, not the date the funds are posted to your bank account. It may take 2-3 business days to reach your account. This processing time is dependent on your bank. Weekends and holidays may delay access to your monies, and you can contact your bank for additional information relating to fund access. ***(Note: If your contract is not eligible for EFT, we do not have validated EFT instructions on file, or your financial institution account information cannot be authenticated, your payments will be sent to your address of record by regular mail)***

Please provide the following information:

Account Name (as it appears on the account)	Bank Name

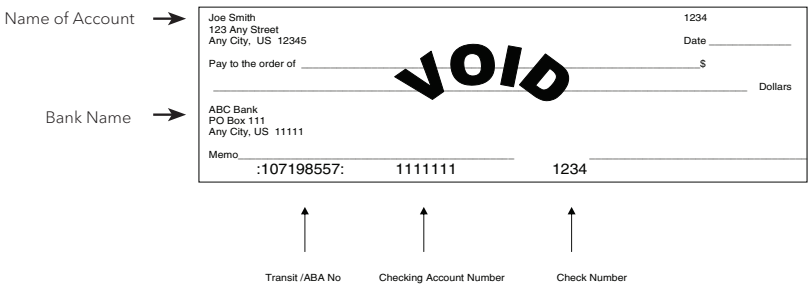
Routing Number (Bottom left of check): ☐☐☐☐☐☐☐☐☐

Account Number (Bottom center of check): ☐☐☐☐☐☐☐☐☐☐☐☐

Type of account: (Your name must appear on the account in order to process your request.)

☐ Checking - A voided/blank check accompanying this form is not required but preferred.

☐ Savings



NOTE: Your signature below authorizes Athene to electronically credit or, if necessary, electronically debit your account. If an incorrect amount is deposited this authorizes Athene to direct your bank to debit this account. This authorization will remain in effect until revoked. Direct Deposit requests can only be accepted for U.S. bank accounts. Athene reserves the right to stop EFT should suspicious activity be identified.

[THIS SECTION INTENTIONALLY LEFT BLANK]

6. FRAUD WARNING STATEMENT, IRS CERTIFICATION AND REQUIRED SIGNATURES

FRAUD WARNING STATEMENT	IRS CERTIFICATION
Residents of NY: 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.	Under penalties of perjury, I certify that: 1. The Social Security Number or Taxpayer Identification Number shown on this form is correct (or I am waiting for a number to be issued to me), and 2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and 3. I am a U.S. citizen or other U.S. person (as defined in the General Instructions of IRS Form W-9), and 4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct. Exemption from FATCA reporting code (if any):_____. (FATCA reporting codes can be found in the General Instructions on IRS Form W-9.) If you are only submitting this form for an account you hold in the United States, you may leave this field blank. Certification Instructions: You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. **The Internal Revenue Service does not require your consent to any provisions of this document other than the certifications required to avoid backup withholding.**

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

If you are signing on behalf of the owner, print your name and provide your signature below and check one of the boxes to indicate the capacity in which you are signing. Provide documentation with the request that verifies your authorization to act on behalf of the owner, if you have not sent this documentation to us previously.

☐ Conservator ☐ Guardian ☐ Power of Attorney ☐ Assignee

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

Attending Physician's Statement

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

1. INFORMATION ABOUT YOUR PATIENT

First Name	Middle Initial	Last Name

Contract Number	Owner Name (if different than Patient)

Date of Birth (mm/dd/yyyy)	Social Security Number (last four digits)	
/ /	XXX-XX-	

2. INSTRUCTIONS

To the Physician: Your patient is requesting a withdrawal from his/her annuity contract under either the confinement or terminal illness provision. To assist us in determining the patient's eligibility for these benefits, we require a statement from you. Please review, complete and sign this form.

3. YOUR RECOMMENDATION

Please choose one of the following options:

☐ Confinement - I have recommended the patient reside in a facility with 24 hour skilled nursing care.
☐ Terminal Illness - This patient has a medical condition that is considered "Terminal".

☐ I agree with this statement. Date of Diagnosis: / /
☐ I disagree with this statement.

4. YOUR CONFIRMATION

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 / /
Print Name	Degree
Office Street Address	
City, State, and Zip Code	

Facility Statement

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

INSTRUCTIONS

To the Facility: Your patient is requesting a withdrawal from his/her annuity contract under the confinement benefit. To assist us in determining eligibility for these benefits, we require a statement from you. Please review, complete and sign this form.

1. INFORMATION ABOUT THE OWNER

First Name	Middle Initial	Last Name
Contract Number		
Date of Birth (mm/dd/yyyy) / /	Social Security Number (last four digits) XXX-XX-	Contact Telephone Number

2. INFORMATION ABOUT THE RESIDENT'S STAY

Name of Resident (if different from the Owner)	
Initial Date of Residence / /	Admitting Physician
Expected Length of Stay	

3. INFORMATION ABOUT THIS FACILITY

Is this facility:	**Yes**	**No**
1. Licensed and operated under state law as:		
a. Convalescent Nursing Facility?	☐	☐
b. Hospice Facility?	☐	☐
c. Hospital?	☐	☐
2. An administrator of programs of treatment and observation that are ordered by and under the supervision of a physician?	☐	☐
3. A provider of 24-hour nursing care under the supervision of a physician or registered nurse?	☐	☐
4. One that maintains a clinical record of each patient?	☐	☐
5. A place that primarily treats mental illness, drug addiction or alcoholism?	☐	☐
6. A government or Veteran facility where a patient is not required to pay?	☐	☐
7. Owned or operated by a family member of the patient?	☐	☐

4. YOUR CONFIRMATION

Under penalties of perjury, I certify that the information provided in this statement is accurate.

Facility Name (Please print)			State License Number
Facility Street Address			
City	State	Zip Code	Phone Number ( )
Authorized Signature X			Date / /
Print Name	Job Title		

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FRAUD NOTICE (Page 1 of 2)

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.

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FRAUD NOTICE (Page 2 of 2)

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

Residents of NJ: Any person who knowingly files a statement of claim containing any false or misleading information is 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.

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.