Request to Convert Term Policy to Whole Life

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

1. POLICY INFORMATION

Term Policy Number	Name of Insured	
Name of Policy Owner	Social Security Number - -	Telephone Number
Street Address (**REQUIRED** if mailing address is a P.O. Box)		
City	State	Zip
Name of Joint Owner, if applicable	Social Security Number - -	

2. REQUEST TO TERM POLICY TO WHOLE LIFE INSURANCE POLICY

Please check one of the following options:

☐ Full conversion of the term policy – no coverage will remain in effect under the term policy.

☐ Partial Conversion of the term policy for $_____.

Indicate disposition of coverage remaining in term policy: ☐ Terminate balance of term policy. ☐ Balance of term policy to remain in force

☐ Check here if your term policy had the Waiver of Premium benefit, and you wish to include this benefit on the new whole life policy.

Please Note: The Waiver of Premium benefit is not available if your term policy did not have this benefit and/or you are now age 55 or older.

3. SELECT BILLING FREQUENCY AND METHOD OF COLLECTION

Please check one of these options: ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly (Available only on EFT)

Please check one of these options: ☐ Direct Regular Notice ☐ EFT

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4. NEW BENEFICIARY ELECTION

Percentages for all beneficiaries must total 100%. If no percentage is provided, proceeds will be divided equally among all surviving beneficiaries. If a new beneficiary is not elected, we will default to your estate.

Full Name of Individual, Trust, or Company*		Check one* ☐ Primary ☐ Contingent	Percentage* %
Social Security Number/Tax Identification Number* ___ ___ ___ ___ ___ ___ ___ ___ ___		Date of Birth* (mm/dd/yyyy) / /	
Street Address		City	State / Zip
Telephone Number	Relationship to Claimant*	Email Address	

Full Name of Individual, Trust, or Company*		Check one* ☐ Primary ☐ Contingent	Percentage* %
Social Security Number/Tax Identification Number* ___ ___ ___ ___ ___ ___ ___ ___ ___		Date of Birth* (mm/dd/yyyy) / /	
Street Address		City	State / Zip
Telephone Number	Relationship to Claimant*	Email Address	

Full Name of Individual, Trust, or Company*		Check one* ☐ Primary ☐ Contingent	Percentage* %
Social Security Number/Tax Identification Number* ___ ___ ___ ___ ___ ___ ___ ___ ___		Date of Birth* (mm/dd/yyyy) / /	
Street Address		City	State / Zip
Telephone Number	Relationship to Claimant*	Email Address	

Full Name of Individual, Trust, or Company*		Check one* ☐ Primary ☐ Contingent	Percentage* %
Social Security Number/Tax Identification Number* ___ ___ ___ ___ ___ ___ ___ ___ ___		Date of Birth* (mm/dd/yyyy) / /	
Street Address		City	State / Zip
Telephone Number	Relationship to Claimant*	Email Address	

***Required fields.**

You may also use additional blank pages completed with beneficiary information. Each blank page must be signed and dated, labeled with the word "Attachment," and include the policy number and all required beneficiary information.

☐ Check this box if you need more space and have attached additional pages to your form.

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5. BANK INFORMATION Complete this section to transfer funds systematically from your bank into your policy.

I (we) hereby authorize Athene to initiate debit entries as follows:

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

Routing /Transit / ABA Number (Bottom left of check): ☐☐☐☐☐☐☐☐☐

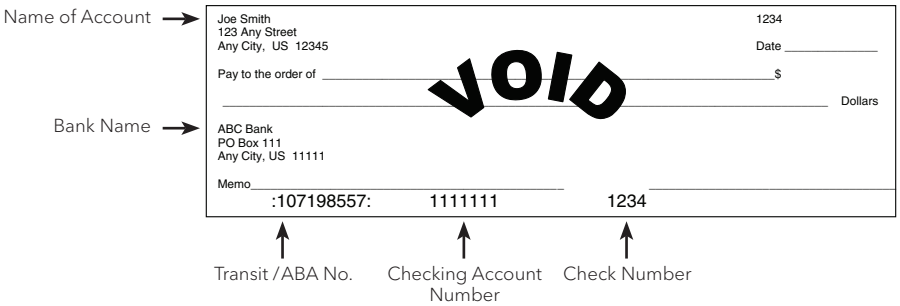
Account Number (Bottom center of check): ☐☐☐☐☐☐☐☐☐☐☐☐

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

☐ Checking - Please attach a voided check for the listed account.

☐ Savings - Please attach a deposit slip for the listed account.

If you are unsure about the correct way to complete the form, please reference the following sample check information.



6. YOUR DIRECT PAYMENT OPTIONS

Amount of Transfer $

Frequency: ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly ☐ Quarterly

Please start the debit transfers from my bank on / / (mm/dd/yyyy)

Indicate the preferred withdrawal date (1st – 28th)

☐ These debit payments are to be applied to a loan on my policy.

The date of transfer is the date the funds are removed from your account, not the date they are posted into your policy. Please allow 2-3 business days for funds to transfer. Due to the pre-note process at your bank, it may take 10-14 days to setup the first transfer of funds. If changes are requested, please allow 15 days for processing.

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7. YOUR CONFIRMATION

This form must be received by the Company within 60 days of the signature date.
I understand that this withdrawal is subject to any applicable surrender or withdrawal charges as defined in the policy.

IRS CERTIFICATION

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	