ATHENE

APPLICATION FOR POLICY CHANGE OR REINSTATEMENT

ATHENE ANNUITY & LIFE ASSURANCE COMPANY, Wilmington, Delaware
Main Administrative Office: 2000 Wade Hampton Blvd. Greenville, SC 29615-1064

General Instructions For Using This Form

*SUBMIT ONE FORM for each policy to be changed or reinstated. A separate Application for Insurance Part II must also be completed for each applicant except as noted below for Tobacco Class change for Express*TERM.

❑ Reinstatement.	Complete all of Section I, Section II.A., Section III, and the Application for Insurance Part II.
❑ Face Amount Changes.	Complete all of Section I, Section II.B., Section III, and the Application for Insurance Part II. Please consult your policy or product guide to determine the type of changes that can be requested, limitations may apply.
❑ Benefit And Rider Changes.	Complete all of Section I, Section II.C., Section III, and the Application for Insurance Part II. Please consult your policy or product guide to determine the type of changes that can be requested, limitations may apply.
❑ Tobacco Class Change.	Complete all of Section I, Section II.D., Tobacco Questionnaire and the Application for Insurance Part II. Agent collected saliva or a urinalysis is required for face amounts at $100,000 and above, excluding ExpressTERM.
❑ Rate Reduction.	Complete all of Section I, Section II. E., Section III, and the Application for Insurance Part II.

Section I: Policy and Insured Information.

Policy Number _____

Insured's Name (*Print First, Middle, Last*) _____ ☐ Male ☐ Female

Date of Birth _____/_____/_____ State of Birth_____Marital Status: ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed

Height *(ft/in)*_____ Weight *(lbs)*_____ SSN/Tax ID_____ E-mail _____

Residence Address *(No PO Box)* _____ Mailing Address *(if different)* _____

City _____ State_____ Zip _____ City _____ State _____ Zip_____

Phone: Day (____)_____ Evening (____)_____ Best time to call: _____

Do you have a driver's license? ☐ Yes License Number _____ State of Issue _____

☐ No If No, provide details _____

Are you employed? ☐ Yes Occupation/Duties _____ Annual Income $ _____

☐ No If No, provide details _____ Household Income $ _____

Have you ever used any tobacco or nicotine products? ☐ Yes ☐ No

If Yes, when did you last use tobacco or nicotine products *(mm/yyyy)* _____ Type_____ Quantity _____

Policyowner Information *(complete only if different than insured)*

Owner's Name *(Print First, Middle, Last)* _____

Residence *(No PO Box)* _____ Mailing Address *(if different)* _____

City _____ State_____ Zip _____ City _____ State_____ Zip_____

Daytime Phone (____)_____Evening (____)_____ E-mail _____

Relationship to Insured _____

Section II.

A. Reinstate *(Please indicate premium amount below and complete Application for Insurance Part II)*

Enclosed is $ _____ premium due.

B. Face Amount Change *(If increasing Face Amount please complete Section III of this form and Application for Insurance Part II)*

☐ Increase Base Policy by $_____ for a total face amount of $ _____

☐ Decrease* Base Policy by $ _____ for a total face amount of $ _____

☐ Decrease*_____Rider by $_____ for a total face amount of $ _____

* Ultimate Face Amount must meet the minimum face amount requirements for your plan or product.

C. Benefit and Rider Changes

(Please complete Section III of this form and Application for Insurance Part II if adding or increasing a benefit or rider. Please complete an Application for Insurance Part II on each proposed insured being added)

Accident Only Disability Benefit ☐ Add ☐ Delete ☐ Decrease Benefit Amount $_____

Accidental Death Benefit ☐ Add ☐ Delete ☐ Decrease Benefit Amount $_____

Critical Illness Benefit ☐ Add ☐ Delete ☐ Decrease Benefit Amount $_____

Disability Income Benefit ☐ Add ☐ Delete ☐ Decrease Benefit Amount $_____

Term Rider ☐ Decreasing ☐ Level _____yr. ☐ Add ☐ Delete ☐ Decrease Benefit Amount $_____

Children's Insurance Benefit Rider ☐ Add ☐ Delete Benefit Amount $_____

Waiver of Premium or Waiver of Monthly Deduction ☐ Add ☐ Delete

Death Benefit Option Change From _____ To_____

Other _____ Benefit Amount $_____

Other Insured Rider *(complete information below if adding)* ☐ Add ☐ Delete Benefit Amount $_____

Proposed Insured's Name *(Print First, Middle, Last)* _____ ☐ Male ☐ Female

Relationship to Primary Insured_____

Date of Birth _____/_____/_____ State of Birth_____Marital Status: ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed

Height *(ft/in)*_____ Weight *(lbs)*_____ SSN/Tax ID_____ E-mail _____

Residence Address *(No PO Box)* _____ Mailing Address *(if different)* _____

City _____ State_____ Zip _____ City _____ State _____ Zip_____

Phone: Day (____)_____ Evening (____) _____ Best time to call: ☐ 8am – Noon ☐ Noon – 5pm ☐ 5pm – 9pm

Do you have a driver's license? ☐ Yes License Number _____ State of Issue _____

☐ No If No, provide details _____

Are you employed? ☐ Yes Occupation/Duties _____ Annual Income $ _____

☐ No If No, provide details_____ Household Income $_____

Have you ever used any tobacco or nicotine products? ☐ Yes ☐ No

If Yes, when did you last use tobacco or nicotine products *(mm/yyyy)* _____ Type_____ Quantity _____

D. Tobacco Class Change (*Please complete Application for Insurance Part II and the Tobacco Questionnaire)*

☐ Change to Non-Tobacco

E. Rate Reduction (*Please complete Application for Insurance Part II)*

☐ Reduce or Remove substandard rating

Section III.

1. In the past five years, have you:	Yes	No	Provide complete details to any Yes answers
A. Been convicted of DUI/DWI, had two or more moving violations, been involved in any motor vehicle accident, in which you were found to be at fault, or had your driver's license suspended or revoked?	☐	☐	
B. Flown as a pilot, student pilot or crew member of any aircraft or have any intentions to do so?	☐	☐	
C. Engaged in underwater diving below 50 feet, racing of any motor powered land vehicle or watercraft, rock or mountain climbing, or any activity requiring the use of a parachute, or any intentions to do so in the next 2 years?	☐	☐	
2. Do you currently have a criminal charge pending against you or have you ever been convicted of, pled guilty or no contest to any felony or misdemeanor or to possession or distribution of drugs or any other illegal substance?	☐	☐	

Authorizations, Declarations & Signatures.

Authorization to Obtain and Disclose Information - I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other health care provider, pharmacy benefit manager, insurance company or reinsurer, government agency, MIB, Inc., formerly known as the Medical Information Bureau, Inc. ("MIB"), consumer reporting agency, employer or other organization, institution or person to disclose to the insurance administrators, underwriting personnel, claims personnel, investigators, legal counsel, and reinsurers of Athene Annuity & Life Assurance Company (the "Company"), the following information pertaining to me or any of my minor children proposed for coverage: (1) employment information; (2) other insurance coverage; (3) prescribed drugs; (4) past and present physical, mental, drug and/or alcohol conditions; (5) motor vehicle records; (6) avocations; (7) general reputation; and (8) other personal characteristics. I authorize the Company, or its reinsurers, to make a brief report of my personal health information to MIB.

I understand and agree to the following:
The Company may collect this information for the purpose of determining eligibility for insurance and investigating claims for benefits. The Company may disclose all or some of my information to its insurance administrators, its reinsurance companies, its agents, MIB, and other persons or organizations performing business or legal services in connection with my application. This authorization is valid for 24 months. A photographic copy of this authorization is as valid as the original and I am entitled to receive a copy of this authorization upon request. I may revoke this authorization at any time by notifying the Company in writing, subject to state law and the rights of anyone who has relied on this authorization. However, that revocation may cause the Company to reject my application.

Acknowledgement - By signing below, each person applying for coverage understands, represents, and agrees to the following: I have read this application and the statements and answers made in this application are true and complete to the best of my knowledge and belief and are made to obtain the insurance applied for. I understand that the insurance I applied for will take effect only if the Company accepts this application and issues the requested change or reinstatement and if, on the date of issue: (1) the required premium for the change or reinstatement has been paid; (2) the proposed insured is alive, and (3) all conditions used to determine the proposed insured's insurability remain as stated in the application. No agent or person other than the Company's Home Office officers has the authority to change or modify this application or the policy applied for.

I (We) also understand that under current tax law, the policy changes requested and/or subsequent policy changes may cause the policy to be a Modified Endowment Contract, which could include taxation of any loans, withdrawals, or surrenders in excess of the amount of premiums paid into the policy.

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

All completed materials must be sent to Athene Annuity & Life Assurance Company, PO Box 789, Greenville SC 29602-1389

Signed on _____
Date

X Signature of Insured _____

X Signature of Proposed Other Insured _____

X Signature of Policy Owner _____

Section IV: For Agent Use, if applicable.

X Signature of Writing Agent _____ Date _____

Printed Name of Writing Agent _____

Agent Information

Name	Agency/Broker Dealer Name	Agent Code	Commission Split

Contact Information

Status updates and requests for additional information should be sent to:

☐ Agent _____ E-mail _____

☐ Name _____ E-mail _____

Special Instructions

_____

_____

APPLICATION FOR INSURANCE PART II **ATHENE ANNUITY & LIFE ASSURANCE COMPANY**
Wilmington, DE

Name _____ Date of Birth ___/___/___ Social Security No. _____
FIRST MI LAST MM / DD / YYYY

Give full details to Yes answers, including specific diagnoses, results, dates of onset and recovery, and names and addresses of all healthcare professionals and medical facilities. ***(Attach additional sheets if necessary.)***

		Details to Yes Answers
1. In the past ten (10) years, have you been tested for; received any treatment, medical advice, or consultation for; been diagnosed with; or required follow-up for:		
a. high blood pressure, chest pain, irregular heart rhythm, palpitations, heart murmur, heart attack, heart failure, angina, phlebitis, peripheral vascular disease, or any other disease or disorder of the heart or blood vessels?	❍ Yes ❍ No	
b. epilepsy, seizures, tremors, dizziness, headaches, fainting spells, stroke, paralysis, head injury, memory loss, Alzheimer's disease, dementia, or any other disease or disorder of the brain or nervous system?	❍ Yes ❍ No	
c. diabetes or any disease or disorder of the pituitary, thyroid, parathyroid, or adrenal glands?	❍ Yes ❍ No	
d. leukemia, lymphoma, tumor or any other form of cancer or malignancy?	❍ Yes ❍ No	
e. anemia, polycythemia, clotting or platelet disorder, or any other disease or disorder of the blood or spleen?	❍ Yes ❍ No	
f. cyst, polyp, lump, or other growth, or any disease or disorder of the breast, skin, or lymph nodes?	❍ Yes ❍ No	
g. asthma, bronchitis, emphysema, COPD, pneumonia, sarcoidosis, sleep apnea, tuberculosis, shortness of breath, persistent hoarseness or cough, coughing up blood, or any other disease or disorder of the lung or respiratory system?	❍ Yes ❍ No	
h. hepatitis, ulcer, blood in stool, colitis, or any other disease or disorder of the stomach, esophagus, liver, pancreas, gallbladder, intestines, colon, or rectum?	❍ Yes ❍ No	
i. protein, blood, or sugar in the urine, or any disease or disorder of the kidney, bladder, prostate, or reproductive system?	❍ Yes ❍ No	
j. arthritis, lupus, chronic fatigue syndrome, fibromyalgia, or any other disease or disorder of the muscles, connective tissues, or bones?	❍ Yes ❍ No	
k. anxiety, depression, schizophrenia, bipolar disorder, suicide attempt(s), or any other mental or nervous disorder?	❍ Yes ❍ No	
l. any disease or disorder of the eyes, ears, nose, or throat?	❍ Yes ❍ No	
2. In the past year, have you used any form of tobacco or nicotine-based products? (If Yes, indicate types, date last used, and quantity per day.)	❍ Yes ❍ No	
3. Have you been diagnosed as having AIDS, AIDS Related Complex (ARC), or any other disorder of your immune system, or had a positive HIV test?	❍ Yes ❍ No	
4. Have you lost more than ten (10) pounds in the last year? (If Yes, give reason.)	❍ Yes ❍ No	
5. To the best of your knowledge, are you now pregnant? (If Yes, provide number of months.)	❍ Yes ❍ No	

6. Are you currently taking any medications (prescription, injection, over the counter) or herbal remedies? (If Yes, list the medication[s]/remedy[ies] with dosage[s] in space provided below.) ❍ Yes ❍ No

MEDICATION/ HERBAL REMEDY	DOSAGE	CONDITION	CURRENTLY TAKING?	MEDICATION/ HERBAL REMEDY	DOSAGE	CONDITION	CURRENTLY TAKING?
			❍ Yes ❍ No				❍ Yes ❍ No
			❍ Yes ❍ No				❍ Yes ❍ No
			❍ Yes ❍ No				❍ Yes ❍ No
			❍ Yes ❍ No				❍ Yes ❍ No
			❍ Yes ❍ No				❍ Yes ❍ No
			❍ Yes ❍ No				❍ Yes ❍ No

APPLICATION FOR INSURANCE PART II **ATHENE ANNUITY & LIFE ASSURANCE COMPANY**
Wilmington, DE

Name _____ Date of Birth ___/___/___ Social Security No. _____
FIRST MI LAST MM / DD / YYYY

Give full details to Yes answers, including specific diagnoses, results, dates of onset and recovery, and names and addresses of all healthcare professionals and medical facilities. ***(Attach additional sheets if necessary.)***

		Details to Yes Answers
7. Do you consume alcoholic beverages? (If Yes, provide amount and frequency.)	❍ Yes ❍ No	
8. Have you:		
a. ever used heroin, cocaine (including crack), LSD, PCP, amphetamines, barbiturates, any derivative of these drugs, or any other controlled substance except as prescribed to you by a healthcare professional licensed to prescribe controlled substances?	❍ Yes ❍ No	
b. ever been arrested for, convicted of, or pled guilty or no contest to drug possession or distribution?	❍ Yes ❍ No	
c. sought counseling for suicide prevention or for thoughts about suicide?	❍ Yes ❍ No	
d. received or been advised by a healthcare professional to receive treatment or counseling for alcohol or drug use?	❍ Yes ❍ No	
e. been advised by a healthcare professional to reduce or stop alcohol or drug use?	❍ Yes ❍ No	
f. been a member of Alcoholics Anonymous (AA) or Narcotics Anonymous (NA)?	❍ Yes ❍ No	
9. Have you requested or received any Worker's Compensation, Social Security, sickness or disability benefits or compensation?	❍ Yes ❍ No	
10. During the past five (5) years, have you:		
a. been advised to have any diagnostic test, surgery, or hospitalization which has not been completed?	❍ Yes ❍ No	
b. had surgery, or been admitted to any medical facility for any condition not disclosed in the preceding questions?	❍ Yes ❍ No	
c. consulted, been examined, or been treated by any healthcare professional for any condition not disclosed in the preceding questions?	❍ Yes ❍ No	
11. Have your natural parents, brother(s) or sister(s) been diagnosed with or died from any of the following conditions prior to age 60? (Check ✓all that apply.)	❍ Yes ❍ No	

❍ cancer ❍ diabetes ❍ stroke ❍ high blood pressure
❍ heart attack, heart failure, or any other cardiovascular disease
(If Yes, please provide full details.)

RELATIVE	CONDITION(S) SUFFERED	AGE AT ONSET	AGE AT DEATH
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

12. Do you have a personal physician? ❍ Yes ❍ No

a. Name _____ d. Telephone # ( ) _____
b. Street _____ e. Date and reason for last consultation _____
c. City/State/Zip Code _____ _____

I represent that the statements and answers given in this Application Part II are true, complete, and correctly recorded.

Signed at: _____
CITY STATE

✗ _____ ✗ _____
SIGNATURE OF THE PROPOSED INSURED DATE SIGNATURE OF THE EXAMINER, BROKER OR WITNESS DATE

ATHENE

TOBACCO QUESTIONNAIRE

Athene Annuity & Life Assurance Company PO Box 19084 Greenville, SC 29602-9084

Insured's Name _____ **Date of Birth** _____

Social Security Number ___ - ___ - ___ **Policy Number** _____

PART I - TOBACCO QUESTIONNAIRE

1. Do you currently use tobacco in any form? ☐ Yes ☐ No

   If "Yes", which type? *(Check all that apply)* ☐ Cigarettes ☐ Dip/Chew/Snuff

   ☐ Pipe/Cigar ☐ Nicotine gum, patch, or other nicotine substitute?

2. Have you previously used a tobacco product and quit? ☐ Yes ☐ No

   If "Yes", how long has it been since you quit? _____

3. Did you use any prescribed medication or one of the nicotine substitutes *(gum, patch, spray, lozenge, etc.)* to assist you in tobacco cessation? ☐ Yes ☐ No

   If "Yes", list type(s): _____

   Do you continue to use this product? ☐ Yes ☐ No

4. Were you advised by a member of the medical profession to quit smoking as a result of the diagnosis of any of the following: lung or oral cancer, coronary artery disease, angina, heart attack, coronary bypass/stent, chronic bronchitis, or emphysema? ☐ Yes ☐ No

   If "Yes", please give details *(diagnosis, date of diagnosis, and treatment).*

   _____

   _____

   _____

5. Have you smoked or used any form of tobacco in the past twelve months? ☐ Yes ☐ No

PART II - SIGNATURES

Signature of Insured _____ Date _____

Signature of Witness _____ Date _____

ATHENE

Authorization for Release of Health Information to Athene Annuity & Life Assurance Company ("Company")

_____

NAME OF INSURED (PLEASE PRINT) DATE OF BIRTH and POLICY NUMBER(S)

I, the undersigned person, authorize any health plan, physician, healthcare professional, hospital, clinic, laboratory, pharmacy, medical facility, pharmacy benefit manager, or other healthcare provider that has provided payment, treatment, or services to the above-referenced Insured or on the Insured's behalf (the "Providers") to disclose the Insured's entire medical record any other information that may be considered protected health information under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") concerning the Insured to the Company, its agents, employees, representatives and reinsurers. This includes information on the diagnosis and treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

I also authorize any insurance company, the Medical Information Bureau, or other organization, institution, or person ("Other Persons") that has any records or knowledge of the Insured or the Insured's health, to give to the Company, its agents, its employees, its representatives and its reinsurers any such information. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I terminate any agreements the Insured made with the Providers or with Other Persons to restrict the Insured's protected health information and I instruct the Providers and Other Persons to release and disclose the Insured's entire medical record and other records or knowledge of the Insured or the Insured's health without restriction.

This protected health information is to be disclosed under this Authorization so that the Company may administer claims and determine or fulfill responsibility for coverage and provision of benefits in respect to the above Policy or Policies.

This Authorization shall remain in force for 24 months following the date of my signature below, and a copy of this Authorization is as valid as the original. I understand that I have the right to revoke this Authorization in writing at any time by sending a written request for revocation to Athene Annuity & Life Assurance Company. I understand that a revocation is not effective if the Providers and Other Persons have relied on this Authorization or to the extent that the Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this Authorization may be re-disclosed and no longer covered by certain federal rules governing privacy and confidentiality of health information.

I also understand that if I refuse to sign this Authorization, the Company may not be able to make any claim or benefit payments under the above Policy. I understand that I have a right to receive a copy of this Authorization.

_____

Signature Date

_____

Printed Name of Insured, Claimant or Personal Representative

_____

Description of Personal Representative's authority or relationship to Insured or Claimant