

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 ExpressTERM.

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.

licy Number Insured's Name (Print First, Middle, Last)			—————————————————————————————————————
Date of Birth/ State of Birth			
Height (ft/in) Weight (lbs) SSN/Tax ID	Ł-mail		
Residence Address (No PO Box)	Mailing Address (if dif	fferent)	
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	lssue
No If No, provide details			
Are you employed? Yes Occupation/Duties		Annual In	come \$
□ No If No, provide details		Househol	d Income \$
Have you ever used any tobacco or nicotine products?	□ No		
If Yes, when did you last use tobacco or nicotine products (n	nm/yyyy) Ty	уре	_ Quantity
Policyowner Information (complete only if different than insure	d)		
Owner's Name (Print First, Middle, Last)			
Residence (No PO Box)		lifferent)	
City State Zip	City	State	e 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. Fac	e Amount Cha	nae	(If increasing	Face Amount	nlease com	nlete Section	III of this form	and Application for	or Insurance Part II	1)
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□ Increase Base Policy	' by \$	for a total face amount of \$
Decrease* Base Poli	cy 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	\Box Add \Box	Delete 🗆 Decrease	e Benefit	Amount \$	
Accidental Death Benefit	□ Add □	Delete Decrease	e Benefit	Amount \$	
Critical Illness Benefit	□ Add □	Delete Decrease	e Benefit	Amount \$	
Disability Income Benefit	□ Add □	Delete Decrease	e Benefit	Amount \$	
Term Rider □ Decreasing □ Levelyr.	□ Add □	Delete Decrease	e 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		То		
Other			Benefit	Amount \$	
Other Insured Rider (complete information below if a	<i>dding)</i> 🗆 Ad	dd 🗆 Delete	Benefit	Amount \$	
Proposed Insured's Name (Print First, Middle, Last	t)			0	Vale 🗖 Female
Relationship to Primary Insured					
Date of Birth/ State of Birth	M	arital Status: 🗖 Marr	ried 🗖 Single 🗖 S	eparated 🗖 Divor	ced 🗖 Widowed
Height (ft/in) Weight (lbs) SSN/Tax	ID	E-r	mail		
Residence Address (No PO Box)		Mailing Address (i	f 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 N	umber		State	e of Issue	
No If No, provide	de details				
Are you employed? Yes Occupation/Duties					
□ No If No, provide details _			Househo	ld Income \$	
Have you ever used any tobacco or nicotine products	s? □Yes □] No			
If Yes, when did you last use tobacco or nicotine	products (mn	n/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

Sigr	ned on
0	Date
Χ	Signature of Insured
Χ	Signature of Proposed Other Insured
	Signature of Policy Owner
	5 ,

Section IV: For Agent Use, if applicable.

X Signature of Writing Agent		Date	
Printed Name of Writing Ag	t		

Agent Information

Name	Agency/Broker Dealer Name	Agent Code	Commission Split

Contact Information

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

Garagent	E-mail
□ Name	E-mail

Special Instructions

Name Date of Birth / Social Security No. Birst M Lest MM/DD/YYYY Give full details to Yes answers, including specific diagnoses, results, dates of one and recovery, and names and addresses of all beathcare professionals and medical facilities. (Atach additional sheets I meessary.) Details to Yes Details to Yes 1. In the past te (10) years, have you been rested for precived any usersment, medical advice, or consultation for, been diagnosed with; or required follow-up for: a. high blood pressure, chest pain, irregular heart inlyam, palpitations, heart marray, heart failure, angina, phkhinis, peripheral vascular disease, or any other disease or disorder of the beart to blood vessels? Details to Yes No b. epilepsy, seizares, tremors, dizziness, headaches, fainting spells, stocke, paralysis, land injury, memory loss. Alz-heimin, or any other disease or any disease or disorder of the pitutiny, thyroid, parathyroid, or adrend glands? Yes No c. diabetes or any disease or disorder of the pitutiny, thyroid, or any dhere form of cancer or malignancy? Yes No e. aering, holytychemia, cloting or placted disorder, or any other disease or disorder of the blood or splen? Yes No e. aering, holytychemia, cloting, or any dhese or disorder of the lung or or esplitatory system? Yes No e. aering, holytychemia, bipolpating blood, or any other disease or disorder of the lung or esplitatory system? Yes No	APPLICATION FOR INSURANCE PART II A	THENE ANNUITY & LIFE ASSURANCE COMPANY Wilmington, DE
Give full details to Yes answers, including specific diagnoses, results, dates of onset and recovery, and numes and addresses of all healthear professionals and medical facilities. (<i>Atuach additional sheet if necessary</i> .) Details to Yes Answers I. In the past term (10) years, have you been tested for received any up tor: a. high blood pressure, chest prin, irregular healt thythm, papitotions, beart marmut, heart attack, heart failure, angian, phlebitis, peripheral vascala disease, or any other disease or disorder of the heart or blood vessels? Yes No b. cplitpsy, szizares, tremors, dizzines, headaches, fainting spells, stroke, paralysis, head injury, memory less, Abricherier disease or disorder of the pituitary, thyroid, parathyroid, or auf cisase or disorder of the pituitary, thyroid, parathyroid, or any disease or disorder of any other disease or disorder of the pituitary, thyroid, parathyroid, or any other growth, or any other disease or disorder of the breast, skin, or lymph nodes? Ves No f. cyst, polyp, lump, or other growth, or any other disease or disorder of the breast, skin, or lymph nodes? Or yes No h. heputitis, ulcer, blood in stool, critis, or any other disease or disorder of the kidney. Juddler, prostate, or reproductive system? Or yes No h. protein, blood, or any other disease or disorder of the kidney. Juddler, prostate, or perpoductive system? Or yes No h. heputitis, ulcer, blood in stool, critis, or any other disease or disorder of the kidney. Juddler, prostate, or exploades, expression, schitzphernia, blooder disease, or disorder of the kidney. Juddler, prostate, or peropudcive system?	Name Date of F	Birth / / Social Security No.
healthcare professionals and medical facilities. (Atach additional sheets if accessary.) In the past en (10) years, have you been tested for; received any treatment, medical advice, or consultation for; been diagnoed with; or required follow-up for: a. high blood pressure, chest pain, irregular heart rightm, palpitations, heart nurmer, heart attack, heart failure, angina, plichtips, peripheral vascular disease, or any other disease or disorder of the heart or blood vessels? O yes No b. epilepsy, seizmes, thereases, headaches, faining spells, stroke, paralysis, head faily, many other disease or disorder of the plutary, thyroid, parathyroid, or adrenal glands? O yes O yes No e. dispets or any disease or disorder of the plutary, thyroid, parathyroid, or adrenal glands? O yes No e. duekemia, lymphoma, tumor or any other form of cancer or malignaney? Yes No e. amenia, polycythemia, clotting or platelet disorder, or any other disease or disorder of the broat, skin, or lymph nodes? O yes No g. ashtma, horonchitis, curphysema, COPD, pneumonia, surcoidousi, skept agane, three passes, three passes, three or perioducitors, or any other disease or disorder of the lung or recent? O yes No h. hepatifis, ulcer, blood in stool, colitis, or any other disease or disorder of the kidney. bladder, prostate, connective tissues, or bones? O yes No i. arthritis, ulpus, chronic faligue syndrome, fibromyalgia, or any other disease or disorder of the muscles, connective tissues, or bones? Yes No t. any disease or disorder of the peyse, aers, nose, or throat? Yes <	FIRST MI LAST	MM / DD / YYYY
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disease or disorder of the muscles, connective tissues, or bones? Q Yes Q No k. anxiety, depression, schizophrenia, bipolar disorder, suicide attempt(s), or any other mental or nervous disorder? Q Yes Q No 1. any disease or disorder of the eyes, ears, nose, or throat? Q Yes Q 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.) Q Yes Q 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? Q Yes Q No 4. Have you lost more than ten (10) pounds in the last year? (If Yes, give reason.) Q Yes Q No 5. To the best of your knowledge, are you now pregnant? (If Yes, provide number of months.) Q Yes Q 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.) MEDICATION/ HERBAL REMEDY DOSAGE CONDITION TAKING? MEDICATION/ HERBAL REMEDY DOSAGE CONDITION TAKING? MEDICATION/ HERBAL REMEDY DOSAGE CONDITION TAKING? MEDICATION/ HERBAL REMEDY DOSAGE CONDITION TAKING? Q Yes Q No Q Yes		
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Name	MI		Date o	f Birth / MM/I	/	Social Se	curity No.		
First		LAST						C . 11	
nealthcare professi	onals and med	including specific d ical facilities. (Atta				covery, and	names and add	resses of all	
7. Do you consume (If Yes, provide					O Yes	O No	Details to Y	es Answers	
3. Have you:		equency.)			9 103	0 110			
	oin. cocaine (i	ncluding crack), LS	D. PCP.						
amphetamine	s, barbiturates	, any derivative of t	hese drugs, or						
		as prescribed to yo scribe controlled su		re	O Yes	O No			
	ested for, conv on or distribut	victed of, or pled gu ion?	ilty or no conte	est to	O Yes	O No			
c. sought couns suicide?	eling for suici	le prevention or for	thoughts abou	t	O Yes	O No			
		a healthcare profese alcohol or drug use		ve	O Yes	O No			
e. been advised drug use?	by a healthcar	e professional to re	duce or stop al	cohol or	O Yes	O No			
f. been a memb Anonymous		cs Anonymous (AA	a) or Narcotics		O Yes	O No			
		d any Worker's Con benefits or comper		cial	O Yes	O No			
0. During the past	five (5) years,	have you:							
	to have any di t been comple	agnostic test, surge ted?	ry, or hospitali	zation	O Yes	O No			
not disclosed	in the precedi	• •		condition	O Yes	O No			
professional	for any conditi	or been treated by a on not disclosed in	the preceding q		O Yes	O No			
from any of the f O cancer	ollowing condi O diabetes heart failure, o	r any other cardiova	? (Check ✓ all the gh blood pressured to the second secon	nat apply.)	O Yes	O No			
		ION(S) SUFFERED	AGE AT ONSET	AGE AT DEATH					
2. Do you have a p	ersonal physic							O Yes	
				d. Telepho			ltation		
		·		e. Date an	u reason fo	r last const	iltation		
		· · · · · ·			•				
-		answers given in th	••		ie, complete	e, and corre	ectly recorded.		
				STATE		_			

ICC09APP-P2(06-09)	MAIN ADMINISTRATIVE OFFICE: 2000 WADE HAMPTON BOULEVARD ♦ GREENVILLE, SC 29615-1064

WATHENE			Товассо Qu	TOBACCO QUESTIONNAIRE			
Athen	e Annuity & Life Assurance Comp	pany PO Box 19084 Gree	nville, SC 29602-9084				
Insured's Name Date of Birth			Date of Birth				
Soci	ial Security Number	Policy Number					
PA	RT I - TOBACCO QUEST	ΓΙΟΝΝΑIRE					
1.	Do you currently use toba	cco in any form?		Yes	🗌 No		
	If "Yes", which type? (<i>Ch</i>		Cigarettes Dip/Chew/Snuff				
2.	Have you previously used	l a tobacco product and	l quit?	Yes	🗌 No		
	If "Yes", how long has it	been since you quit?		_			
3.	Did you use any prescribe <i>lozenge, etc.)</i> to assist you		f the nicotine substitutes (gum, patch, spray,	🗌 Yes	🗌 No		
	If "Yes", list type(s):						
	Do you continue to use the	is product?		Yes	🗌 No		
4.		llowing: lung or oral c	profession to quit smoking as a result of the cancer, coronary artery disease, angina, heart s, or emphysema?	Yes	🗌 No		
	If "Yes", please give detai	ils (diagnosis, date of a	diagnosis, and treatment).				

PART II - TOBACCO STATEMENT

MATHENE

I do not now smoke or use tobacco, nor have I smoked or used any form of tobacco for at least the past twelve months.

Signature of Insured Date

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.

MATHENE

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