Authorization to Obtain Disclosure Information

ATHENE
Athene.com

Mail or fax completed form to:
Mailing Address: P.O. Box 1555, Des Moines, IA 50306-1555
Overnight Address: 7700 Mills Civic Parkway, West Des Moines, IA 50266-3862
Fax: 866-709-3922

Athene Annuity & Life Assurance Company of New York
1 Blue Hill Plz, Ste 1672, Pearl River, NY 10965

Contact us:
Customer Contact Center - Tel: 888-266-8489

1. REPLACED COMPANY INFORMATION

Company Name:	Telephone Number:	Fax Number:	
Street Address:	City:	State:	Zip:
Name of Contact:	Telephone/Extension Number		

List Policy/Contract Number(s):_____

2. AUTHORIZATION AND REQUEST FOR DISCLOSURE

By signing this form, I authorize the undersigned agent and Athene Annuity & Life Assurance Company of New York to obtain account information from my current insurer related to my existing life insurance policy or annuity contract.
I am considering replacement of this policy/contract with: ☒ Fixed Annuity

Insured/Annuitant Name:	Date of Birth:	Social Security Number (Optional):
Print Owner Name:		
Print Joint Owner Name:		
Full or Partial Replacement: ☐ Full ☐ Partial $_____ or %_____ ☐ Penalty Free Amount		

3. REPLACEMENT INFORMATION

Replacing Agent Name:	Agent Number:		
Address:	City:	State:	Zip:
Telephone Number:	Fax Number:		

4. PROPOSED ATHENE ANNUITY & LIFE ASSURANCE COMPANY OF NEW YORK PRODUCT

Product Name and Contract Number (if available):

5. REQUIRED SIGNATURES

Owner Signature: Date:	Joint Owner Signature: Date:
To the best of my knowledge, all policies/contracts being replaced have been disclosed. Agent Signature:	Date: