

# Authorization to Release



**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

- Use this form to designate 1 or 2 authorized individuals to obtain information about your policy/contract(s).
- This authorization allows for the release of information ONLY. It does NOT allow the authorized person to make changes to the policy/contract(s) listed on this release form.
- Attached documentation must be signed and dated by the owner.
- This authorization is valid until revoked by the owner. The owner reserves the right to revoke this authorization at any time for any reason by calling us at the number listed above or by submitting a written request.
- When contacting our offices the authorized party will need to verify the last four digits of the OWNER'S Social Security Number, the OWNER'S date of birth and the OWNER'S password (if applicable) when requesting information.

## 1. INFORMATION ABOUT THE OWNER

Individual, Trustee or Company Name		Contract/Policy Number(s)			
If Trust, list Trust Name and Trust Date					
Mailing Address		City	State	Zip	Country
Street Address ( <b>REQUIRED</b> if mailing address is a PO Box)		City	State	Zip	Country
Social Security Number (last four digits) X X X - X X -		Date of Birth (mm/dd/yyyy) / /		Email Address	
Personal Phone ( ) -	Business Phone ( ) -	<input type="checkbox"/> Address Change Requested (Confirmation of this change will be sent to you prior to processing this request.)			

## 2. AUTHORIZED PARTY #1

Full Name*					
Mailing Address*		City*	State*	Zip*	Country
Street Address ( <b>REQUIRED</b> if mailing address is a PO Box)		City	State	Zip	Country
Personal Phone ( ) -	Business Phone ( ) -		Email Address		

\* Required Information

Check if have attached additional sheets for more than two authorized parties.

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### 3. AUTHORIZED PARTY #2

Full Name*					
Mailing Address*		City*	State*	Zip*	Country
Street Address ( <b>REQUIRED</b> if mailing address is a PO Box)		City	State	Zip	Country
Personal Phone ( ) -	Business Phone ( ) -		Email Address		

\* Required Information

### 4. LIMITATIONS

Please list below any information you would **not** like to be released to the listed authorized party(ies):


### 5. YOUR CONFIRMATION

I authorize the named person/people to receive information on the referenced policy/contract(s):

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

If you are signing on behalf of the owner, check one of the boxes to indicate the capacity in which you are signing and provide documentation to verify your authorization to act on behalf of the owner.

Conservator    Guardian    Power of Attorney    Assignee

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