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Partial Withdrawal / Full Surrender Request

Athene Annuity & Life Assurance Company of New York

1. Contract Information

Contract Number

Name of Annuitant

Name of Owner (*if different from Annuitant*)

Social Security No. or Tax I.D. No.

Street Address, City, State, Zip (*indicate mailing address for check*)

Telephone Number

Name of Joint Owner (*if applicable*)

Social Security No. or Tax I.D. No.

2. Distribution Election – I wish to withdraw or surrender from my annuity, the amount indicated below.

(This form may not be used for TSA/403(b) contracts. Please call the service center for appropriate form.)

Please Check ☑ One

☐ Maximum amount available without a surrender charge

For the following two options, please select one of the following: ☐ Gross Amount ☐ Net Amount. *If no selection is made, a "Gross Amount" withdrawal will be processed.*

☐ Specified Dollar Amount of $_____

☐ Specified Percentage of: _____% of the accumulation value

☐ Full Surrender – the policy, or policy Data Page, must be submitted with this request. If you lost your policy, please check the box below:

☐ Declaration of Lost Policy: I declare this policy has been lost or destroyed and it has not been assigned, pledged or otherwise disposed of, and, I release the Company from all liability under the original policy and agree to return the policy to the Company if found.

3. Income Tax Withholding

FEDERAL WITHHOLDING - Please Check ☑ One *(If no election is made, 10% federal income tax will be withheld)*

☐ Do not withhold
☐ Withhold 10%
☐ Withhold a flat amount of $_____, or a specific percentage of _____%

STATE WITHHOLDING If you reside in one of the following states – CA, DC, DE GA, IA, KS, MA, ME, MI*, NE, NC, OK, OR, VT, or VA - and federal income tax is withheld, we will automatically withhold state income tax. If your state allows, you may opt out. See the enclosed ***State Tax Withholding Information***, to determine if your state allows you to opt out. You may elect to withhold if you live in any state except AK, FL, NH, NV, SD, TN, TX, WA, WY. Please check one of the following boxes:

☐ Do not withhold, unless required by law.
☐ Withhold a flat amount of $_____, or a specific percentage of _____%

*MICHIGAN residents: Please refer to www.michigan.gov/taxes for information regarding the MI W-4P form for tax withholding or opt out information. If this form is not received, State Income Tax will be withheld.

Notice: Federal law requires withholding a minimum of 10% federal income tax from taxable distributions, unless you elect not to have taxes withheld, or specify a different withholding amount. Withholding will only apply to that portion of your distribution that is includable in your income subject to federal income tax. You may revoke this withholding election at any time by contacting Athene Annuity & Life Assurance Company of New York in writing unless the distribution is from a tax sheltered annuity or qualified plan that is eligible to be rolled over to an IRA or qualified plan. In these cases, the distribution will be subject to a 20% mandatory withholding therefore you may not elect to waive the federal income tax withheld. Electing not to withhold at this time does not release the liability for payment of federal and, if applicable, state income tax on the taxable portion of your payment. You may incur tax penalties if your withholding and tax payments are not adequate.

Athene Annuity & Life Assurance Company of New York will not render tax advice. We suggest that you consult tax advisor regarding your financial situation.

Athene Annuity & Life Assurance Company of New York

4. Disclosure

Please Read Carefully

1. I understand that if I am currently set up to automatically receive Required Minimum Distribution (RMD) payments from this contract, this partial withdrawal **will affect** the amount I will receive for my RMD.
   a) If this partial withdrawal is equal to, or greater than, the calculated RMD amount for this calendar year, no RMD payment(s) will be made for the remainder of this calendar year, and the scheduled RMD payment(s) will begin again next year.
   b) If this partial withdrawal is less than the calculated RMD amount for this calendar year, the RMD payment(s) will be reduced by the amount of this partial withdrawal. Once the calculated RMD amount has been paid out, no further RMD payment(s) will be made until next year.
2. I understand that by requesting a surrender or partial withdrawal of my annuity contract, I may incur surrender charges.
3. I understand that requesting a surrender or partial withdrawal of my annuity contract may result in tax consequences.
4. I have no plans to replace* this annuity contract with another annuity contract; or
5. I do plan to replace* this annuity contract and have made my agent aware so that appropriate replacement forms and other required documentation can be completed.

*The National Association of Insurance Commissions (NAIC) definition of a replacement includes any *transaction in which a new policy or contract is to be purchased, and it is known or should be known to the proposing agent that by reason of the transaction, an existing policy or contract has been or is to be surrendered.*

5. Certification of Taxpayer Identification Number

Under penalties of perjury, I certify that:

1. The 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 for IRS Form W-9, however if you are 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 return.

6. Required Signature(s)

X_____ _____

Signature of Owner Date

X_____ _____

Signature of Joint Owner (*if applicable*) Date

STATE TAX WITHHOLDING INFORMATION

Athene Annuity & Life Assurance Company of New York

Neither Athene Annuity & Life Assurance Company of New York, nor any of its employees, agents or representatives gives legal, tax or accounting advice. The information provided here is merely a summary of our understanding of the withholding requirements as they relate to our contract, and is not a warranty or representation concerning such matters. We will not be responsible for any penalties incurred by you, should the amount distributed be incorrect. We recommend you consult with your tax advisor.

If your state is not mentioned below, we will not withhold state income tax, regardless of whether or not federal withholding is elected. However, upon request, we will withhold state income tax.

AR, CA, DC, DE, GA, IA, KS, MA, ME, MI, MS, NC, NE, OK, OR, VA, VT - Requires that if you elect to have federal income tax withheld, we must automatically withhold state income tax also. (Some exceptions may apply, please see below)

AR	• IRAs and all other "qualified" plans - State tax withholding is required, you cannot opt out. • Non-Qualified – Periodic payments – State tax withholding is required, you cannot opt out. • Non-Qualified - Lump Sum Distributions – State tax withholding is required, unless you opt out using state form AR4P which must be completed and returned.
CA	You may opt out of state withholding, even if you elect to have federal income tax withheld.
DC	• IRAs and all other "qualified" plans - State tax withholding is required, you cannot opt out. • Non-Qualified - You may opt out of state withholding, even if you elect to have federal income tax withheld.
DE	If the distribution is subject to 20% mandatory federal withholding on TSA or other qualified retirement plan, then state income tax must be withheld. Otherwise, you may opt out of state income tax withholding.
GA	You may opt out of state withholding, even if you elect to have federal income tax withheld.
IA	You may NOT opt out of state withholding, even if you elect to have federal income tax withheld.
KS	If the distribution is subject to 20% mandatory federal withholding on TSA or other qualified retirement plan, then state income tax must be withheld. Otherwise, you may opt out of state income tax withholding.
MA	You may NOT opt out of state withholding, even if you elect to have federal income tax withheld.
ME	If the distribution is subject to 20% mandatory federal withholding on TSA or other qualified retirement plan, then state income tax must be withheld. Otherwise, you may opt out of state income tax withholding.
MI	State tax withholding is required, unless you opt out using Michigan State Tax Form MI W-4Pm which must be completed and returned.
MS	State tax withholding is required on all premature distributions (typically distributions under age 59½) , Otherwise, you may opt out of state income tax withholding.
NC	If the distribution is subject to 20% mandatory federal withholding on TSA or other qualified retirement plan, then state income tax must be withheld. Otherwise, you may opt out of state income tax withholding.
NE	You may opt out of state withholding, even if you elect to have federal income tax withheld.
OK	You may NOT opt out of state withholding, even if you elect to have federal income tax withheld.
OR	If the distribution is subject to 20% mandatory federal withholding on TSA or other qualified retirement plan, then state income tax must be withheld. Otherwise, you may opt out of state income tax withholding.
VA	IRA or SEP-IRA – You may opt out of state income tax withholding. All other distributions, you may NOT opt out.
VT	If the distribution is subject to 20% mandatory federal withholding on TSA or other qualified retirement plan, then state income tax must be withheld. Otherwise, you may opt out of state income tax withholding.

AK, FL, NH, NV, SD, TN, TX, WA, WY – State income tax withholding is NOT allowed in these states.

Electronic Funds Deposit Authorization

Athene Annuity & Life Assurance Company of New York

1. Contract Information

Contract Number

Name of Annuitant

Name of Contract Owner

Social Security Number

Street Address, City, State, Zip

Telephone Number

Name of Joint Owner (*If applicable*)

2. Bank Account Information

Type of Account: ☐ Checking Account ☐ Savings Account

Name of Financial Institution

Full Name on Bank Account

Additional Name(s) on Bank Account

ABA Routing Number (*9 digits*)

Bank Account Number (4-17 digits)

Please attach a VOIDED check for checking accounts; OR a deposit slip for savings accounts to be used for account information verification.
(Deposit slips will not be accepted for checking accounts)

☐ Check this box for paperless and online accounts, and ensure that both the routing number and account number is entered in the spaces above.
If you have a paperless/online account, please include a letter from the bank showing the owner name(s) of the account. If the bank's letter lists joint owners both must sign this form.

3. Authorization For Electronic Funds Deposit

As the bank account owner, I authorize Athene Annuity & Life Assurance Company of New York to:

- Automatically deposit funds, for all withdrawals from this annuity contract, to the checking or savings account referenced above.
- Withdraw funds which may be inadvertently deposited to the account referenced above. This includes, but is not limited to, any payments made after the death of the annuitant.

This authorization will remain in effect until written notice of a change of account, or termination, is delivered to Athene Annuity & Life Assurance Company of New York in a timely manner, so as to afford the company an opportunity to act thereon. (Such requests should be received no less than 10 business days prior to due date of the next payment.) In no event shall a "change" or " termination" request include entries processed prior to receipt of such notice.

Signature of Bank Account Owner

Signature of Co-Bank Account Owner *(if applicable)*

Date

4. Acknowledgement of Contract Owner(s) *(If not the same as the Bank Account Owner)*

By signing where indicated below, I hereby acknowledge my approval for Athene Annuity & Life Assurance Company of New York to withdraw funds from the annuity contract, and request that those funds be deposited into the bank account referenced above.

*X*_____
Signature of Owner

Date

*X*_____
Signature of Joint Owner *(If applicable)*

Date

REQUEST FOR WITHDRAWAL UNDER TERMINAL ILLNESS/CONFINEMENT WAIVER

Athene Annuity & Life Assurance Company of New York

Owner/Annuitant's Statement *Any person, who knowingly and with intent to deceive or defraud, files a claim containing false, incomplete or misleading information, may be in violation of state law. Use of mail to defraud is a violation of federal law.*

In order to qualify for this benefit, please confirm the Annuitant meets the following requirements:

1. The annuitant is at least 50 years of age: ☐Yes ☐No
2. The annuity contract has been in force for at least one year (State of Kansas is 2 years): ☐Yes ☐No

If the answer to either of these questions is no, the annuitant does not qualify for the benefit.

To help ensure prompt processing of your claim, please make sure all forms are complete.

1) Name:	2) Date of Birth:	3) Social Security Number:	4) Are you a resident of the United States? ☐Yes ☐No
5) Owner/Annuitant's address:		6) List contract numbers for all Athene Annuity & Life Assurance Company of New York contracts owned by the Owner/Annuitant:	
7) Name and address of physician: Phone Number: (____) _____		8) Is the condition a result of: A. Illness: ☐Yes ☐No B. Accident: ☐Yes ☐No If yes, to either, please provide details:	
9) What Type of facility is providing your care? ☐ Long Term Care Facility ☐ Skilled Nursing Facility ☐ Intermediate Nursing Facility ☐ Hospital		10) Name and address of facility: Phone Number: (____) _____	
11) Date patient entered the care facility: _____			

For New York residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

I authorize any physician, hospital, clinic, insurance company, or any other organization, that has any records or knowledge of my health and disability to give Athene Annuity & Life Assurance Company of New York that information. A photocopy of this authorization shall be as valid as the original.

_____ _____

Signature of Owner/Annuitant Date

Certain Insurance Departments require that we advise you of the following statements:

For Alaska Residents: A person who knowingly and with intent to injure, defraud or deceive an insurance company, files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

For Arizona Residents: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

For Alabama, Arkansas, Kentucky, Ohio, and West Virginia Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and maybe subject to fines and confinement in prison.

For California Residents: For your protection, California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

For Colorado Residents: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

For Delaware, Idaho and Indiana Residents: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

For District of Columbia Residents: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

For Florida Residents: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

For Louisiana, New Mexico and Rhode Island Residents: NOTICE: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For Maine, Tennessee Virginia and Washington Residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

For Minnesota Residents: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

For New Hampshire Residents: Any person who, with purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA
638:20.

For New Jersey Residents: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

For Oklahoma Residents: WARNING - Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

For Pennsylvania Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

For Maryland Residents: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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ATTENDING PHYSICIAN'S STATEMENT

Athene Annuity & Life Assurance Company of New York

This form may not be completed by a physician who is a member of the patient's family or who is an employee of the facility in which the patient is/was confined.

Patient's Name _____ Patient's Date of Birth _____

Diagnosis or nature of illness or injury that required confinement _____

Date you were first consulted for the patient's condition _____

1. Has the patient previously been treated for the same or similar symptoms? ☐ Yes ☐ No
2. Date the patient was admitted for long term care:_____
3. Does the patient need continual supervision due to deterioration or loss of intellectual capacity? ☐ Yes ☐ No
4. Prognosis: Indicate the patient's life expectancy (please check one):

   ☐ 0 - 12 months ☐ 12 - 24 months ☐ Longer than 24 months
5. Status of Activities of Daily Living (Please check all that the patient is unable to perform independently)

   ☐ Bathing ☐ Dressing ☐ Transferring ☐ Continence ☐ Eating ☐ Toileting

PHYSICIAN'S REMARKS:

_____
Physician's Name (Please Print) Medical License Number

_____
Address/City/Zip

_____
Telephone Number of Office

_____
Physician's Signature Date

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TERMINAL ILLNESS/CONFINEMENT WAIVER
Facility or Provider of Care Services Form

Athene Annuity & Life Assurance Company of New York

1. CONTRACT INFORMATION - To be completed by the designated annuitant or person acting on his/her behalf:

Contract Number

Name of Patient/Designated Annuitant

Name of Contract Owner

Social Security Number

Street Address, City, State, Zip

Telephone Number

Name of Joint Owner (*If applicable*)

2. AUTHORIZATION TO RELEASE INFORMATION - To be completed by the designated annuitant or person acting on his/her behalf:

Name of Facility or Care Services Provider:_____

Address of Facility or Care Services Provider:_____

Phone Number of Facility or Care Services Provider: _____

I authorize the Facility or Care Services Provider, as named above, to release information relevant to my confinement and/or care, and to provide such information to Athene Annuity and Life Assurance Company of New York, or its representative.

Signature of Patient/Designated Annuitant _____Date_____

3. THIS SECTION SHOULD BE COMPLETED BY A REPRESENTATIVE OF THE FACILITY OR CARE SERVICES PROVIDER

1. Date on which patient's confinement, or care, began. _____/_____/_____
2. Date on which patient's confinement or care ceased (if applicable). _____/_____/_____
3. Was the confinement or care continuous? ☐ Yes ☐ No
4. Briefly describe the services provided to this patient: _____
5. Briefly describe the facility, if patient is confined: _____
6. Under what type of license does the Facility or Care Services Provider operate? _____

PLEASE RETURN A COPY OF CURRENT LICENSE(S) OFTHE FACILITY OR CARE SERVICES PROVIDER WITH THIS FORM.

4. SIGNATURE

Signature of Care Provider, or Representative of Facility

Date

Printed Name and Title

Address (City, State Zip Code)

( )
Telephone Number

Athene Annuity & Life Assurance Company of New York will not be responsible for payment of any fees associated with the completion of this form.