REQUEST FOR WITHDRAWAL UNDER CONFINEMENT BENEFIT PROVISION

Benefit 10

Athene Annuity & Life Assurance Company

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 annuitant has been confined for 90 consecutive days: ☐Yes ☐No
3. The annuity contract has been in force for at least one year (State of Kansas is 2 years): ☐Yes ☐No

If the answer to any 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 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 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

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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Athene Annuity & Life Assurance Company

BENEFIT 10 -CONFINEMENT
or TERMINAL ILLNESS PROVISION
Facility or Provider of Care Services Form

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, 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 will not be responsible for payment of any fees associated with the completion of this form.