ATHENE

Athene Annuity & Life Assurance Company

ENHANCED CARE RIDER
Request for Monthly Benefits

1. CONTRACT INFORMATION

Contract Number

Name of Designated Annuitant

Name of Contract Owner

Social Security Number

Street Address, City, State, Zip

Telephone Number

Name of Joint Owner (*If applicable*)

YOUR ENHANCED CARE RIDER MUST BE IN EFFECT FOR AT LEAST SIX CONSECUTIVE YEARS, AND THE DESIGNATED ANNUITANT MUST BE UNABLE TO PERFORM AT LEAST TWO (2) ACTIVITIES OF DAILY LIVING (ADL) WITHOUT HUMAN ASSISTANCE; OR HAVE A DEFICIENCY DUE TO THE PRESENCE OF A COGNITIVE IMPAIRMENT, AND BE RECEIVING CARE SERVICES. *Refer to your Enhanced Care Rider for Benefit Conditions, Benefit Procedures and the definitions of Daily Living without Human Assistance, Cognitive Impairment and Care Services.*

The accumulation value of your annuity contract will be increased by the amount of any monthly benefits under the Enhanced Care Rider. If you would like to withdraw the monthly benefit amount(s), you will need to submit the V1215i Partial Withdrawal/Full Surrender Form (for a one time withdrawal) or the AA248 Systematic Withdrawal form (for monthly withdrawals).

2. THIS SECTION SHOULD BE COMPLETED BY THE OWNER(S)

Has your Enhanced Care Rider been in effect for at least 6 consecutive years, as measured from its effective date, and each succeeding 12-month period?

☐ NO – You are not eligible for the monthly benefit at this time. Please submit your request once the 6-year deferral period has been met. *(Refer to your Enhanced Care Rider for additional details.)*

☐ YES – Is this request for monthly benefits within 30 days from the date the Benefit Conditions are met by the Designated Annuitant?

☐ YES ☐ NO – If no, please explain the reason for the delay in requesting the monthly benefits

3. THIS SECTION SHOULD BE COMPLETED BY THE DESIGNATED ANNUITANT; OR REPRESENTATIVE OF THE DESIGNATED ANNUITANT *(Please refer to the Enhanced Care Rider for details and definitions of the following)*

Does the Designated Annuitant meet one of the following Benefit Conditions?

a) Unable to perform at least two (2) Activities of Daily Living without Human Assistance – as defined in the Enhanced Care Rider
b) Have a deficiency due to the presence of Cognitive Impairment.- as defined in the Enhanced Care Rider

☐ Yes ☐ No

Is the Designated Annuitant receiving Care Services – as defined in the Enhanced Care Rider

☐ Yes ☐ No

If the answer to <u>BOTH</u> questions is "yes", please provide supporting details

If the answer to <u>EITHER</u> question is "no", the Designated Beneficiary does not meet the Benefit Conditions of the Enhanced Care Rider at this time. Please submit your request when both of the above conditions are met.

4. ACKNOWLEDGEMENTS/SIGNATURES *(Please check the following boxes to indicate your understanding)*

- ☐ I/We understand that the company, upon receipt of this written request, will work with the Designated Annuitant, or his/her representative, to confirm the Benefit Conditions are satisfied.
- ☐ I/We understand the company reserves the right to do a telephone interview, perform an on-site nursing assessment or require a physical exam when and as often as the company determined is reasonable, while making its determination.
- ☐ I/We understand that a new written request for monthly benefits must be sent to the company if the monthly benefits cease for a period of 30 days or more.
- ☐ I/We understand that there is a one-time forty-five (45) day Elimination Period requirement that must be satisfied once the company determined the Benefit Conditions have been met by the Designated Annuitant
- ☐ I/We understand that at any time the Company reserves the right to require proof of continuing receipt of Care Services and face-to-face assessments of the Designated Annuitant's inability to perform at least 2 Activities of Daily Living without Human Assistance or deficiency due to the presence of a Cognitive Impairment.

Signature of Owner	Date
Signature of Joint Owner (if applicable)	Date
Signature of Spouse (Required if resident of a Community Property State)	Date
Signature of Designated Annuitant (or Representative)	Date