ATHENE

REQUEST TO BEGIN INCOME PAYMENTS FROM GLWB RIDER

Athene Annuity & Life Assurance Company

1. CONTRACT INFORMATION

Contract Number	Name of Annuitant
Name of Contract Owner	Social Security Number
Street Address, City, State, Zip	Telephone Number
Name Joint Owner	Social Security Number

PLEASE NOTE:

a) Once the Lifetime Income withdrawal benefit is started, all previous systematic withdrawals [(including RMD, 72(t)] will be discontinued.
b) If you have the Enhanced Guaranteed Lifetime withdrawal rider and choose to elect the Joint Life payout, the increase in income payments due to not being able to perform 2 of 6 daily activities will no longer be available

2. DISTRIBUTION ELECTION

I wish to start receiving income from my GLWB Rider.

Please Check ☑ One (Note that only one withdrawal option per year is allowed.)

- ☐ Guaranteed Lifetime Withdrawal Benefit Rider
- ☐ Enhanced Guaranteed Lifetime Withdrawal Benefit Rider

Frequency

- ☐ Monthly
- ☐ Quarterly
- ☐ Semi-Annually
- ☐ Annually

Begin benefits on _____ *(Cannot be the 29th, 30th or 31st)*

Calculate benefits based on:

- ☐ Single Life
- ☐ Joint Life (only available on owner and spouse) Spouse's Date of Birth _____

Amount:

- ☐ Maximum Lifetime Withdrawal Amount
- ☐ Specified Dollar Amount $_____ (must be below the Lifetime Withdrawal Amount)

Delivery of Funds:

- ☐ Check (not available if you selected to receive your payments monthly)

Address to mail check City ST Zip

- ☐ Direct Deposit (Please complete the Electronic Funds Deposit Authorization form)

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3. INCOME TAX WITHHOLDING

FEDERAL WITHHOLDING – Please Check ☑ One (If no election is made, federal income tax will be withheld.)

- ☐ Withhold 10%
- ☐ Withhold another amount: $_____ or _____%
- ☐ Do not withhold federal income tax

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. If you do not reside in one of the states previously listed, you may still elect to withhold UNLESS you live in AK, FL, NH, NV, SD, TN, TX, WA, WY. Please check one of the following boxes.

- ☐ Do not withhold. I live in one of the states listed above, but my state allows me to opt out
- ☐ Withhold $_____ or _____%

*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 the MI W-4P is not returned, we are required to withhold state income tax.

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 in writing. 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.

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

4. CERTIFICATION OF TAXPAYER IDENTIFICATION

Under penalties of perjury, I certify that:

1. The Social Security Number or 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.) If you are only 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.

5. ACKNOWLEDGMENT/SIGNATURE(S)

I(We) submit this request for the proposed changes with a full and complete understanding of each and every requested change. I(We) hereby request that such changes be made.

Signature of Owner	Date
Signature of Joint Owner (if applicable)	Date

Electronic Funds Deposit Authorization

Athene Annuity & Life Assurance Company

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 both the routing number and account number are 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 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 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 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

ENHANCED GLWB RIDER CLAIM FORM

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Athene Annuity & Life Assurance Company

1. Policy/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. Owner's/Annuitant's Statement (Please Print)

Physician's Name

Physician's Phone Number

Physician's Address

City

ST Zip

1. Your condition is due to: ☐ Illness ☐ Injury. Please describe condition below.

2. What type of facility is providing your care?

   ☐ Long Term Care Facility ☐ Intermediate Nursing Facility

   ☐ Skilled Nursing Facility ☐ Hospital

3. Date you entered the facility? _____

Name of Facility

Facility's Phone Number

Facility's Address

City

ST ZIP

3. Acknowledgement / Signature(s)

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.

Signature of Owner

Date

Signature of Joint Owner (if applicable)

Date

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ENHANCED GLWB RIDER
Facility or Provider of Care Services Form

Athene Annuity & Life Assurance Company

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.

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.