Deferred Annuity Claim Form for Individual Beneficiaries

ATHENE
www.atheneannuity.com

Mail or fax completed form to:
P.O. Box 1555, Des Moines, IA 50306-1555 Fax: 866 709 3922

Contact us:
Annuity Customer Contact Center – Tel: 888 266 8489
Press Option 1, then Option 3 to speak to a Claim Specialist

Athene Annuity and Life Company
7700 Mills Civic Parkway, West Des Moines, IA 50266-3862

Athene Annuity & Life Assurance Company of New York
Nyack, NY 10960

Use this form to request claim payment for an individual beneficiary (natural person) on an Athene deferred annuity contract. Complete pages 1-6 of this form in their entirety, including appropriate signatures and dates on page 6, and submit with a copy of the certified death certificate showing cause and manner of death.
Note: For a non-natural entity beneficiary (e.g. estate, trust, corporation), use the Deferred Annuity Claim Form for Entity Beneficiaries (20773).

1. ANNUITY CONTRACT NUMBERS - This section is required.

List **ALL** annuity contract numbers for which you are claiming the death benefit:

2. DECEDENT INFORMATION - This section is required.

Complete this section with information about the deceased person.

Full Name		Also Known As (if applicable)
Date of Birth (mm/dd/yyyy) / /	Date of Death (mm/dd/yyyy) / /	Social Security Number ___ ___ ___-___ ___-___ ___ ___ ___

3. BENEFICIARY/CLAIMANT INFORMATION - This section is required.

If you are the named beneficiary, complete this section with information about yourself. If you are claiming on behalf of the named beneficiary, as a Conservator, Guardian, or Attorney-in-Fact, complete this section with information about the beneficiary and provide your information in Section 8.

In what capacity are you claiming the death benefit?

☐ Spouse of decedent

☐ **Residents of PA:** Check here if there was a pending divorce at the time of death.

☐ Non-Spouse: Your relationship to decedent:_____

☐ On behalf of the named beneficiary, as Conservator, Guardian, or Attorney-in-Fact

Full Name*		Social Security Number* ___ ___ ___-___ ___-___ ___ ___ ___	
Also Known As (if applicable)		Date of Birth* (mm/dd/yyyy) / /	
Resident Address* (must be a street address)	City*	State*	Zip Code*
Mailing Address (if different than Resident Address)	City	State	Zip Code
Email Address		Telephone Number	

***Required fields**

This form must be signed and dated on page 6.
Pages 1-6 must be completed and returned.

4. PAYMENT OPTIONS - An election in this section is required.

Consider your options carefully. Refer to the Deferred Annuity Claim Instructions for Individual Beneficiaries (17981) for additional information about each option. Be aware that upon distribution of the funds, you will need to include the taxable portion of the distribution in your gross income for tax purposes. You may want to consult your financial or tax advisor before making your decision. If you are making elections for multiple contracts, specify the contract number(s) next to each election.

Once your claim has been processed, your Payment Option cannot be changed.

- **To ensure your claim is processed by December 31, all requirements must be recevied in good order by December 1.**

☐ **A. Lump Sum Payment** – I elect this option for the following contract number(s): _____

This option provides the death claim payment in a single sum paid to you. The taxable portion of the claim payment is reported as taxable income in the year the check is issued. **If it is after December 31 of the year following the date of death, this is the only payment option available.**

☐ **B. Periodic Payments** – I elect this option for the following contract number(s): _____

This option provides a series of fixed payments, distributed over your lifetime or a fixed number of years, based on your elections below. Payments must begin no later than December 31 of the year following the date of death. Once payments begin, they cannot be changed.

Option: ☐ **Life Only** ☐ **Period Certain** ☐ **Life and Period Certain**

If no option is elected, we will default to Period Certain.

Duration: _____ years

If no duration, or a duration less than 5 years is elected, we will default to 5 years.

Frequency: ☐ **Monthly** ☐ **Quarterly** ☐ **Semi-Annually** ☐ **Annually**

If no frequency is elected, we will default to Annually.

☐ **C. Transfer/1035 Exchange** – I elect this option for the following contract number(s): _____

This option allows funds to be moved directly from one account to another, as a 1035 Exchange, Non-Qualified Taxable Transfer, Trustee-to-Trustee Transfer, or Inherited IRA. Transfer of funds may be internal, to a new Athene annuity, or external, to an account at another company.

Type of Transfer/1035 Exchange: (Internal 1035 Exchanges are available for spouse beneficiaries only.)

☐ Internal transfer to a new Athene annuity (new application required)
- ☐ Application included ☐ Application to follow

☐ External transfer to another company (transfer paperwork required)
- ☐ Transfer paperwork included ☐ Transfer paperwork to follow

Tax Qualification of Transfer/1035 Exchange:

Non-Qualified: ☐ 1035 Exchange ☐ Non-Qualified Taxable Transfer

Qualified: ☐ Trustee-to-Trustee Transfer

☐ Inherited IRA – Available for qualified contracts only and must be processed by December 31 of the year following the date of death

Required Minimum Distribution (RMD):

☐ Please process decedent's current year RMD prior to the transfer, if applicable

☐ **D. Deferral** – I elect this option for the following contract number(s): _____

This option delays your claim payment for up to 5 years from the date of death. The claim must be paid on or before December 31 of the 5th year following the date of death. You may request your claim payment at anytime within the deferral period by submitting a new claim form.

Qualified Contracts: This option is not available if the decedent had reached the Required Beginning Date for minimum distributions. You must continue to take Required Minimum Distributions (RMDs) beginning in the year after the decedent's death. If the decedent was not required to take minimum distributions, you may elect the Deferral option and delay distribution until December 31 of the 5th year following the date of death.

This form must be signed and dated on page 6.
Pages 1-6 must be completed and returned.

4. PAYMENT OPTIONS - An election in this section is required. (continued)

☐ **E. Spousal Continuation** – I elect this option for the following contract number(s): _____
This option continues the existing contract in your name with the original effective date and the same contract number. No death benefit distribution will occur and this ownership change is not taxable. This option is only available if your spouse is the deceased and you are the sole beneficiary. This option is not available on an Inherited IRA contract. No death benefit distribution will occur and no death benefit interest will be applied to the contract. If you continue the existing contract and request surrender at a later date, you will not receive the Death Benefit Value. **This option must be processed by December 31 of the year following the date of death.**

5. PAYMENT INSTRUCTIONS - Complete this section if you elected Payment Options A, B, or RMD in Option C.

Select where you would like your payment to be sent. If no option is selected, a check will be mailed to the Mailing Address provided in Section 3 of this form. Do not complete this section for a transfer/1035 exchange. The check will be mailed to the address provided on the transfer paperwork.

☐ A. Mail check to the Mailing Address provided in Section 3.

☐ B. Mail check to an alternate address:

C/O		
Street Address		
City	State	Zip

☐ C. Mail check to my active Athene producer:
If this producer is not active, the check will be mailed to the Mailing Address provided in Section 3.

Producer Name	Producer Code

☐ Check this box to authorize this producer to receive information about your claim.

☐ D. Overnight - Send the proceeds via Overnight Mail. I am aware there will be a $25.00 charge deducted from the payment amount. (This option is not available if mailing check to a Post Office Box.)

[THIS SECTION INTENTIONALLY LEFT BLANK, CONTINUE TO NEXT PAGE]

6. TAX WITHHOLDING - Complete this section if you elected Payment Options A or B or RMD in Option C.

Withholding Notice – Please read this notice prior to making your withholding elections.

- All or part of the payment you receive may be included in your gross income for tax purposes.
- The taxable portion of the distribution is subject to federal (and potentially state) withholding unless you elect not to have withholding apply. You may elect not to have withholding apply by marking the appropriate box below.
- If you elect not to have withholding apply or if you do not have enough federal income tax withheld, you may be responsible for payment of estimated tax.
- **Tax withholding elections do not apply to interest accrued from the date of death to the date of payment.**
- If an election is not made, no federal or state taxes will be withheld from your payment.
- If federal withholding is elected and no percentage is specified, we will default to 10%.
- If federal withholding is elected and you reside in a state that requires mandatory withholding, state income taxes will also be withheld.
- If state withholding is elected and no percentage is specified, we will default to 5% or the mandatory percentage required in your state, if applicable. (Required income tax withholding rules supersede any election made.)
- Federal income tax withholding must be elected if state income tax withholding is elected. If state withholding is elected and federal withholding is not specified, we will default to 10% federal withholding.
- **We encourage you to consult your tax advisor regarding any questions you have about taxes.**

Federal Withholding Election (choose A or B)

☐ A. I **do not** want federal income tax withheld from my payment.
☐ B. I **do** want federal income tax withheld from my payment at the rate of _____%.

State Withholding Election (choose A or B)

☐ A. I **do not** want state income tax withheld from my payment.
☐ B. I **do** want state income tax withheld from my payment at the rate of _____ %.

Residents of AR: Distributions you receive from qualified annuity contracts that are eligible to be rolled over tax free to an IRA or qualified plan are subject to a flat 5% state withholding rate. The 5% withholding rate is required, and you cannot choose not to have income tax withheld from eligible rollover distributions.

Residents of VT: You are required to give a spousal indication. Please check the appropriate selection below:

☐ Single ☐ Married

Foreign Claimants

- If you are not a United States Citizen, we are required to withhold up to 30% of the benefit payable to you.
- A special withholding rule exists if you are a citizen of, and reside in, a country with which the United States has an income tax treaty. A list of treaty countries is provided in IRS Publication 901 (United States Tax Treaties) which can be obtained from the IRS Website at www.IRS.gov.
- In order for us to institute a lower treaty rate, your United States Taxpayer Identification Number (TIN) must be provided on a completed and signed IRS Form W-8BEN (Certificate of Foreign Status of Beneficial Owner for United States Tax Withholding). If an IRS Form W-8BEN has not been received and all other documents necessary to settle the claim have been received, we will proceed with settlement of the claim and withhold 30% of the benefit payable to you.
- If you do not have a United States TIN, one can be obtained from the Internal Revenue Service by using IRS Form W-7 (Application for IRS Individual Taxpayer Identification Number). Note: The Company does not facilitate the beneficiary's application for a TIN. Please do not return IRS Form W-7 to our office.

7. NEW BENEFICIARY ELECTION - Complete this section if you elected Payment Options B or E.

Percentages for all beneficiaries must total 100%. If no percentage is provided, proceeds will be divided equally among all surviving beneficiaries. If a new beneficiary is not elected, we will default to your estate.

Full Name of Individual, Trust, or Company*	Check one* ☐ Primary ☐ Contingent	Percentage* %	
Social Security Number/Tax Identification Number* ___ ___ ___ ___ ___ ___ ___ ___ ___	Date of Birth* (mm/dd/yyyy) / /		
Street Address	City	State	Zip
Telephone Number	Relationship to Claimant*		

Full Name of Individual, Trust, or Company*	Check one* ☐ Primary ☐ Contingent	Percentage* %	
Social Security Number/Tax Identification Number* ___ ___ ___ ___ ___ ___ ___ ___ ___	Date of Birth* (mm/dd/yyyy) / /		
Street Address	City	State	Zip
Telephone Number	Relationship to Claimant*		

Full Name of Individual, Trust, or Company*	Check one* ☐ Primary ☐ Contingent	Percentage* %	
Social Security Number/Tax Identification Number* ___ ___ ___ ___ ___ ___ ___ ___ ___	Date of Birth* (mm/dd/yyyy) / /		
Street Address	City	State	Zip
Telephone Number	Relationship to Claimant*		

Full Name of Individual, Trust, or Company*	Check one* ☐ Primary ☐ Contingent	Percentage* %	
Social Security Number/Tax Identification Number* ___ ___ ___ ___ ___ ___ ___ ___ ___	Date of Birth* (mm/dd/yyyy) / /		
Street Address	City	State	Zip
Telephone Number	Relationship to Claimant*		

***Required fields.**
You may also use additional blank pages completed with beneficiary information. Each blank page must be signed and dated, labeled with the word "Attachment," and include the contract number and all required beneficiary information.

☐ Check this box if you need more space and have attached additional pages to your form.

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8. AUTHORIZATION AND SIGNATURE(S) - This section is required.

Please sign and date below. If you do not sign and date this page, processing of your claim will be delayed.

By signing below, I acknowledge:

- I have read this form in its entirety and the information provided on pages 1-6 is complete and accurate to the best of my knowledge.
- I have read the applicable State Fraud Notice on pages 7-8.

Notice to Residents of NY: 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.

IRS CERTIFICATION

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 on 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 tax return.

The Internal Revenue Service does not require your consent to any provisions of this document other than the certifications required to avoid backup withholding.

Signature of Beneficiary/Claimant X	Signature Date (mm/dd/yyyy) / /
Full Name of Beneficiary/Claimant (please print)	

If you are signing on behalf of the beneficiary, check one of the boxes to indicate the capacity in which you are signing and provide documentation (e.g. Power of Attorney documents, court appointment paperwork, etc.) to verify your authorization.

☐ Conservator ☐ Guardian ☐ Power of Attorney

Signature X			Signature Date (mm/dd/yyyy) / /
Full Name and Title* (please print)			
Address*	City*	State*	Zip Code*
Email Address		Telephone Number	

***Required fields.**

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This form must be signed and dated on page 6.
Pages 1-6 must be completed and returned.

9. FRAUD NOTICE (Page 1 of 2)

Important: This is part of the request form. Please review the applicable fraud notice for your state below.

All states (except as noted below): 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.

Residents of AK: 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.

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

Residents of AZ: 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.

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

Residents of CO: 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 producer of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Residents of DC: Any person who knowingly and 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.

Residents of DE, ID, IN, OK: 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.

Residents of FL: 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.

Residents of KY: Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

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

Residents of ME, TN, VA, WA: 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.

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

Residents of NH: Any person who, with a 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 N.H. Rev. Stat. Ann. §638:20.

9. FRAUD NOTICE (Page 2 of 2)

Important: This is part of the request form. Please review the applicable fraud notice for your state below.

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

Residents of NM: 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 civil fines and criminal penalties.

Residents of OH: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Residents of OR: Any person who knowingly presents a materially false or fraudulent claim for payment of a loss or benefit, or knowingly presents materially false information in an application for insurance, may be guilty of a crime and may be subject to fines and confinement in prison, depending on state law.

Residents of PA: 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.

Residents of PR: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss of any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and , upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand ($5,000) dollars and not more than ten thousand ($10,000) dollars, or a fixed term of imprisonment for three (3) years, or both penalties. If aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years. If extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

Residents of RI: 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.

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