Authorization to Release Information

ATHENE
www.athene.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

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

Athene Annuity & Life Assurance Company of New York
Pearl River, NY 10965

INSTRUCTIONS

- Use this form to designate 1 or 2 authorized individuals to obtain information about your policy/contract(s).
- This authorization allows for the release of information ONLY. It does NOT allow the authorized person to make changes to the policy/contract(s) listed on this release form.
- You can also call one of our Customer Contact Centers listed above to make this request.
- Attached documentation must be signed and dated by the owner.
- This authorization is valid until revoked by the owner. The owner reserves the right to revoke this authorization at any time for any reason by calling us at the number listed above or by submitting a written request.
- When contacting our offices the authorized party will need to verify the last four digits of the OWNER'S Social Security Number, the OWNER'S date of birth and the OWNER'S password (if applicable) when requesting information.

1. INFORMATION ABOUT THE OWNER

Individual, Trustee or Company Name		Contract/Policy Number(s)		
If Trust, list Trust Name and Trust Date				
Mailing Address		City	State	Zip	Country
Street Address (**REQUIRED** if mailing address is a PO Box)		City	State	Zip	Country
Social Security Number (last four digits) X X X - X X -	Date of Birth (mm/dd/yyyy) / /		Email Address	
Personal Phone ( ) -	Business Phone ( ) -	☐ Address Change Requested (Confirmation of this change will be sent to you prior to processing this request.)		

2. AUTHORIZED PARTY #1

Full Name*				
Mailing Address*		City*	State*	Zip*	Country
Street Address (**REQUIRED** if mailing address is a PO Box)		City	State	Zip	Country
Personal Phone ( ) -	Business Phone ( ) -		Email Address	

* Required Information

☐ Check if have attached additional sheets for more than two authorized parties.

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3. AUTHORIZED PARTY #2

Full Name*				
Mailing Address*	City*	State*	Zip*	Country
Street Address (**REQUIRED** if mailing address is a PO Box)	City	State	Zip	Country

Personal Phone ( ) -	Business Phone ( ) -	Email Address

* Required Information

4. LIMITATIONS

Please list below any information you would **not** like to be released to the listed authorized party(ies):

5. YOUR CONFIRMATION

I authorize the named person/people to receive information on the referenced policy/contract(s):

Owner Signature X	Owner's Title (if corporation or trust)	Date (mm/dd/yyyy) / /
Joint Owner Signature X	Print Name	Date (mm/dd/yyyy) / /

If you are signing on behalf of the owner, check one of the boxes to indicate the capacity in which you are signing and provide documentation to verify your authorization to act on behalf of the owner.

☐ Conservator ☐ Guardian ☐ Power of Attorney ☐ Assignee

Signature X	Print Name	Date (mm/dd/yyyy) / /