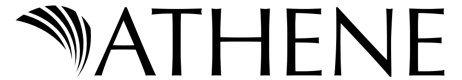
Confinement Waiver Instructions



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

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

Dear Requestor:

It is our understanding that you may need to exercise the Confinement Waiver provided in your contract.

To help you with this process, we have enclosed three forms that we ask you to complete and return to us for review.

- Form 55423 - Confinement Waiver Withdrawal Request

  Please complete this form to request the amount desired under the Confinement Waiver. If you would like taxes to be withheld from your check, please indicate the amount on this form. Please refer to your contract for additional information regarding the amount available to you under this waiver.

- Form 55424 - Attending Physician's Statement

  To qualify for the Waiver, the confinement must be recommended by the patient's doctor. Please ask the attending physician to complete this form to confirm that confinement was recommended.

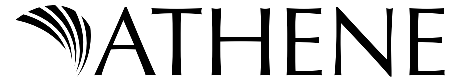
- Form 55425 - Facility Statement

  The Facility must also meet certain requirements in order to qualify for the Waiver. Please ask a representative of the Facility to complete this form to provide us the needed information about the Facility.

Please be aware that this transaction may result in a taxable event to the current owner and if the owner is under 59 1/2, a 10% IRS penalty may also apply. We recommend you seek the advice of your Financial or Tax Professional before proceeding.

Please send the forms to us at the Post Office Box listed at the top of this form.

Confinement Waiver Withdrawal Request



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1. INFORMATION ABOUT THE OWNER

First Name		Middle Initial	Last Name		
Contract Number					
Date of Birth (mm/dd/yyyy) / /	Social Security Number (last four digits) XXX-XX-		Contact Telephone Number		
Mailing Address			Email Address		
City			State	Zip	Address Change Requested:* ☐
Street Address (**REQUIRED** if mailing address is a P.O. Box)					
City				State	Zip

* For your protection, confirmation of your address change will be sent to you prior to processing this request.

INSTRUCTIONS

To the Owner: Use this form to request a withdrawal under the confinement waiver of your contract.

2. YOUR DISTRIBUTION OPTIONS

Please select from the following options:

☐ A withdrawal in the Gross Amount of $______________.______

☐ A full surrender of the contract, which will exhaust all funds of the contract.

Please refer to your contract for additional information regarding the amount available to you under the waiver.

3. YOUR TAX WITHHOLDING ELECTION

The IRS requires that we withhold 10% Federal Income Tax from your distribution unless you advise us otherwise. If you elect NOT to have Federal Income Tax withheld, you are still liable for the payment of any tax that may be due. You may also be subject to tax penalties under the estimated tax payment rules if your payments of estimated tax and withholding, if any, are inadequate.

If you **do not** want us to withhold 10% of your distribution, please select one of the options below.

☐ Do not withhold Federal or State income taxes from my payment

☐ Withhold ________% or $______________.______ Federal income tax from my payment

☐ Withhold ________% or $______________.______ State income tax from my payment

We encourage you to consult your tax advisor to clarify your personal tax position.

Confinement Waiver Withdrawal Request

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4. YOUR CONFIRMATION

NOTE: this form must be received by the Company within 60 days of the signature date.

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.

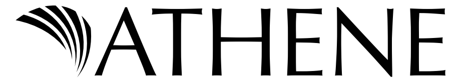
Owner's Signature X	Owner's Title (if corporation or trust)	Date (mm/dd/yyyy) / /
Joint Owner's Signature X	Joint Owner Name (please print)	Date (mm/dd/yyyy) / /

If you are signing on behalf of the owner, print your name and provide your signature below and check one of the boxes to indicate the capacity in which you are signing. Provide documentation with the request that verifies your authorization to act on behalf of the owner, if you have not sent this documentation to us previously.

☐ Conservator ☐ Guardian ☐ Power of Attorney ☐ Assignee

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

Attending Physician's Statement



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1. INFORMATION ABOUT YOUR PATIENT

First Name	Middle Initial	Last Name
Contract Number	Owner Name (if different than Patient)	
Date of Birth (mm/dd/yyyy) / /	Social Security Number (last four digits) XXX-XX-	

2. INSTRUCTIONS

To the Physician: Your patient is requesting a withdrawal from his/her annuity contract under either the confinement or terminal illness provision. To assist us in determining the patient's eligibility for these benefits, we require a statement from you. Please review, complete and sign this form.

3. YOUR RECOMMENDATION

Please choose one of the following options:

☐ Confinement - I have recommended the patient reside in a long term care facility with 24 hour skilled nursing care.
☐ Terminal Illness - This patient has a medical condition that is considered "Terminal".

☐ I agree with this statement. Date of Diagnosis: / /
☐ I disagree with this statement.

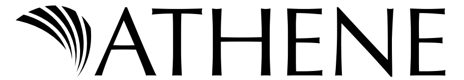
4. YOUR CONFIRMATION

Under penalties of perjury, I certify that:

1. The owner is my patient, and
2. The information provided in this statement is accurate.

Signature of Physician	Date / /
Print Name	Degree
Office Street Address	
City, State, and Zip Code	

Facility Statement



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INSTRUCTIONS

To the Facility: Your patient is requesting a withdrawal from his/her annuity contract under the confinement benefit. To assist us in determining eligibility for these benefits, we require a statement from you. Please review, complete and sign this form.

1. INFORMATION ABOUT THE OWNER

First Name	Middle Initial	Last Name
Contract Number		
Date of Birth (mm/dd/yyyy) / /	Social Security Number (last four digits) X X X - X X -	Contact Telephone Number

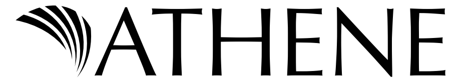
2. INFORMATION ABOUT THE RESIDENT'S STAY

Name of Resident (if different from the Owner)	
Initial Date of Residence / /	Admitting Physician
Expected Length of Stay	

3. INFORMATION ABOUT THIS FACILITY

Is this facility:	**Yes**	**No**
1. Licensed and operated under state law as:		
a. Convalescent Nursing Facility?	☐	☐
b. Hospice Facility?	☐	☐
c. Hospital?	☐	☐
2. An administrator of programs of treatment and observation that are ordered by and under the supervision of a physician?	☐	☐
3. A provider of 24-hour nursing care under the supervision of a physician or registered nurse?	☐	☐
4. One that maintains a clinical record of each patient?	☐	☐
5. A place that primarily treats mental illness, drug addiction or alcoholism?	☐	☐
6. A government or Veteran facility where a patient is not required to pay?	☐	☐
7. Owned or operated by a family member of the patient?	☐	☐

Facility Statement



4. YOUR CONFIRMATION

Under penalties of perjury, I certify that the information provided in this statement is accurate.

Facility Name (Please print)			State License Number
Facility Street Address			
City	State	Zip Code	Phone Number ( )
Authorized Signature X			Date / /
Print Name	Job Title		