Terminal Illness (Accelerated Benefit Disclosure) Waiver Instructions

ATHENE
www.atheneannuity.com

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

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

Contact us:
Annuity Customer Contact Center - Tel: 888 266 8489

Dear Requestor:

It is our understanding that you may need to exercise the Terminal Illness Waiver for your contract.

To help you gather the needed information, we have enclosed two forms that need to be completed and returned to us for review and processing. Each form is described below:

- 81058 - Terminal Illness Waiver Withdrawal Request

  Please complete this form to request the amount desired under the Terminal Illness Waiver. Also, 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.

- 55424 - Attending Physician's Statement

  To qualify for the Waiver, the Terminal Illness must be verified by the patient's doctor. Please ask the attending physician to complete this form.

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.

Any withdrawals taken under this Waiver will reduce your contract values by the amount of the withdrawal. If you elect a full surrender of your annuity under the Waiver, your contract will terminate. It will have no contract value and will not provide a death benefit to the named beneficiary.

Please send both forms to us once they are complete. We will review your request upon receipt of both forms.

Terminal Illness Waiver Withdrawal Request

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7700 Mills Civic Parkway, West Des Moines, IA 50266-3862

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

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		
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 terminal illness 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.

Terminal Illness 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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7700 Mills Civic Parkway, West Des Moines, IA 50266-3862

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

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	