Life Insurance Claim Form

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:
Life 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

1. LIFE POLICY NUMBERS

List all of the life policy numbers for which you are claiming the death benefit:

2. INFORMATION ABOUT THE DECEASED

Deceased Name		Also Known As (if applicable)
Date of Birth (mm/dd/yy) / /	Date of Death (mm/dd/yy) / /	Social Security Number

☐ An original certified death certificate is attached, showing cause and manner of death. (Required)

3. BENEFICIARY INFORMATION

In what capacity are you claiming the death benefit?

☐ **Beneficiary (individual)** - Complete one form for each beneficiary. If former spouse, complete as Other.

☐ **Trustee** - Skip to Section 5. The claimant must also complete Section 6, "Distribution of Funds".

☐ **Executor, administrator, or personal representative** - Include court certificate of appointment. Please complete the form with the estate information rather than your personal information. The claim is payable to the estate.

☐ **Charity or corporation** - The claimant must complete Section 6, "Distribution of Funds".

☐ **On behalf of minor child, as attorney-in-fact or as custodian or guardian** - Include appropriate documentation. See the Annuity/Life Claim Checklist (Form 17981) for more information.

☐ **Foreign Beneficiary** - Natural person: include a completed and signed IRS form W-8BEN. (Entity: include completed and signed IRS form W-8-IMY; see Section 9.)

☐ **Spouse of decedent** - Pennsylvania resident with divorce proceedings pending.

☐ **Other** - List below. (If former spouse, include copy of the divorce decree and settlement agreement.)

4. BENEFICIARY CONTACT INFORMATION (please print)

Beneficiary Name/Name of Estate/Charity/Corporation		Also Known As (if applicable)	
Date of Birth (mm/dd/yy) / /	Social Security / Tax Identification Number (TIN)	Telephone	
Street Address	City	State	Zip Code
Mailing Address	City	State	Zip Code
Email Address		Relationship to Deceased	

NOTE: If you are not a Trustee, skip Section 5.

5. TRUST VERIFICATION (Complete only if the beneficiary is a Trust.)

NOTE: If you, as a Trustee, have questions regarding values or distribution options, please complete sections 1, 2, 3, 5 and 12 and return BEFORE calling our office. This will allow us to verify trustee information over the phone.

I/We, the duly appointed and acting Trustees of the below named Trust, which is the beneficiary or assignee of claim proceeds, hereby certify to Athene Annuity and Life Company or Athene Annuity & Life Assurance Company of New York ("the Company"), under penalty of perjury, the following:

NOTE: The POA/Guardian for the Owner is not authorized to act on the behalf of a Trustee.

1.	Full Name of Trust:	
2.	Address for Trust:	
3.	Trust Phone Number:	
4.	Trust Date(s): (Original and Amended Trust Dates, if applicable.)	
5.	State Law that Governs the Trust:	
6.	State(s) taxes to be reported in:	

7. The Trust allows that any Trustee named shall act:
☐ Solely and independently, OR ☐ Together with any or all co-trustees named.
(If checked, all trustees must sign in Section 13.)

Trustee Name(s) - Please Print

1.	2.
3.	4.

8.	The Trust or Personal Tax Identification Number (TIN) used for tax reporting: **NOTE: The TIN should be the same number you will be using for the trust, not the trustee.**	

9. The Trust Agreement containing the terms of the Trust, including the names of the Trustee(s) and the date of the Trust, was formed and domiciled in the United States or one of its Territories and is now in full force and effect.

10. The trustee(s) of the above named trust has/have the authority either by terms of the Trust Agreement or applicable state law to cause the Trust to accept death proceeds as Beneficiary (or assignee) and to release the Company from any liability in consideration of proceeds being paid.

6. DISTRIBUTION OF FUNDS

If the beneficiary is a trust or entity, please list the names of any individuals or entities who will receive 25% or more of any payment distributed from the trust or entity originating from this policy. (REQUIRED)

NOTE: You are required to notify us of any changes regarding who receives payments.

Name	Date of Birth (mm/dd/yy) / /	Social Security / Tax Identification Number		
Street Address		City	State	Zip
Telephone Number	Relationship to Current Owner		Percentage %	

Name	Date of Birth (mm/dd/yy) / /	Social Security / Tax Identification Number		
Street Address		City	State	Zip
Telephone Number	Relationship to Current Owner		Percentage %	

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6. DISTRIBUTION OF FUNDS (Continued from Page 2)

Name	Date of Birth (mm/dd/yy) / /	Social Security / Tax Identification Number		
Street Address		City	State	Zip
Telephone Number	Relationship to Current Owner		Percentage %	

Name	Date of Birth (mm/dd/yy) / /	Social Security / Tax Identification Number		
Street Address		City	State	Zip
Telephone Number	Relationship to Current Owner		Percentage %	

7. SETTLEMENT OPTIONS (Elect one Settlement Option only.)

☐	**Lump sum settlement**
☐	**Settlement option -** Please complete the *My Primary Beneficiary(ies)* section if you select this option. By selecting the Settlement Option you are electing to have an annuity set up for you. Please contact our home office to request an illustration and other options. Duration (minimum of 5 years): _____ Frequency: ☐ Monthly ☐ Quarterly ☐ Semi-Annual ☐ Annual Option: ☐ Life ☐ Certain Period

8. MY PRIMARY BENEFICIARY(IES) - Complete ONLY if you select Settlement Option above.

Complete this section if you selected Settlement Option in Section 6. Percentages for all beneficiaries must total 100%.

Individual, Trust or Company Name			Relationship to Insured	Percentage %
Date of Birth (mm/dd/yy) / /	Telephone Number	Social Security / Tax Identification Number	☐ Distribute the proceeds per stirpes	
Street Address		City	State	Zip

Individual, Trust or Company Name			Relationship to Insured	Percentage %
Date of Birth (mm/dd/yy) / /	Telephone Number	Social Security / Tax Identification Number	☐ Distribute the proceeds per stirpes	
Street Address		City	State	Zip

☐ If you need more space you may use additional blank pages completed with beneficiary information, signed and dated on each sheet. Include the word "Attachment" and policy number on each additional sheet.

9. FOREIGN BENEFICIARY

Beneficiary is NOT a United States citizen (Foreign Beneficiary) — If the beneficiary is not a United States Citizen, the Company is required to withhold up to 30% of any gain and/or interest from the benefit payable to the beneficiary. A special withholding rule exists if the beneficiary is a citizen of, and resides 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 or from an IRS office in the beneficiary's country of residence. In order for the Company to institute a lower treaty rate, the beneficiary's United States Taxpayer Identification Number (TIN) must be provided.

- If the beneficiary does 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.
- If all other documents necessary to settle the claim(s) have been provided, the Company will proceed with settlement of the claim and withhold 30% of the gain and/or interest.
- **Foreign Beneficiary (Natural person):** A completed and signed IRS Form W-8BEN, (Certificate of Foreign Status of Beneficial Owner for United States Tax Withholding) must be provided.
- **Foreign Beneficiary (Entity):** Life Claim Form must be signed by an authorized representative of the organization. A copy of the corporate resolution, bylaws or other documents verifying that signer(s) of the claim form are authorized to act on behalf of the organization must be provided.
  A completed and signed IRS Form W-8-IMY (Certificate of Foreign Intermediary, Foreign Flow-Through Entity, or Certain U.S. Branches for United States Tax Withholding) must be provided.

10. AGENT DELIVERY

☐ I would like the proceeds of this claim to be delivered to me by my active Athene agent, listed below:

Athene Agent (Print your ACTIVE Athene Agent's Name)

11. **FRAUD WARNING STATEMENT**	12. **IRS CERTIFICATION**
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.	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.**

13. REQUIRED SIGNATURES

As the beneficiary, trustee(s), executor(s), legal guardian, custodian, attorney-in-fact, or signing officer, please sign your name and date below. **If you do not sign and date this page, processing of your claim will be delayed.**
By signing below, you are confirming that you have reviewed the applicable state fraud notice.
If a Trust and the named trustee is a company/corporation, the person(s) signing below on behalf of the corporate trustee are duly authorized by the company/corporation to do so.

Your Signature X	Your Title (if Trust or Corporation)	Date (mm/dd/yy) / /
Trustee Signature X	Name and Title (please print)	Date (mm/dd/yy) / /
Trustee Signature X	Name and Title (please print)	Date (mm/dd/yy) / /
Trustee Signature X	Name and Title (please print)	Date (mm/dd/yy) / /
Trustee Signature X	Name and Title (please print)	Date (mm/dd/yy) / /

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 to verify your authorization to act on behalf of the beneficiary.

☐ Conservator ☐ Guardian ☐ Power of Attorney

Signature X	Name (please print)	Date (mm/dd/yy) / /

14. **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 agent 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.

14. **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: ny 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.