Pension Plan Verification

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

1.	Full Name of Plan:	
2.	Policy/Contract Number(s):	
3.	Address of Plan:	
4.	Plan Tax Identification Number (TIN):	
5.	Date of Plan:	
6.	Name of current Plan Administrator and/or authorized signers for the Plan Administrator / Plan Trustee / Officers (attach a list that is signed and dated if all will not fit on form).	
	1.	3.
	2.	4.

7. Signatures required by the Plan Documents to authenticate forms and/or requests on behalf of the Plan in connection with insurance/annuity products (please check one):

- ☐ Any of the current authorized signers of the Plan Administrator or any of the Trustees/Officers, acting alone;
- ☐ All of the authorized signers of the Plan Administrator and Trustees/Officers, acting together; (signatures of all named parties will be required)
- ☐ Other (explain) _____

CERTIFICATIONS BY PLAN ADMINISTRATOR/TRUSTEE/OFFICER

The Plan Administrator/Trustee/Officer states and agrees that:

The Plan, if named owner, is authorized under the terms of the Plan to purchase and/or hold life insurance or an annuity on the life of the insured/annuitant. If named beneficiary, the Plan is authorized to receive proceeds as provided under the terms of the life insurance/annuity contract. I/We have also determined the insurance/annuity product is appropriate for the Plan's purpose and the terms of the insurance/annuity product conforms to the income distribution requirements, if any, of the Plan.

I/We Certify that the Company may rely solely on this Verification and the information provided for policy/contract administration purposes and the Company has no obligation to investigate the terms of the Plan or the authority of the Plan Administrator/Trustee/Officer. The Company expressly denies responsibility regarding the use and applications of any payments made by the Plan and the Plan Administrator/Trustee/Officer will hold the Company harmless from any action the Company takes at the direction of the Plan Administrator/Trustee/Officer.

The Plan Administrator/Trustee/Officer declares that each and every authorized signer of the Plan Administrator and/or Trustee/Officer is bound by this certification. It is further understood that the Company may rely upon the direction of the named Plan Administrator/Trustee/Officer until the Company receives written notification at its Home Office of a change of the Plan Administrator/Trustee/Officer. Furthermore, the Plan Administrator/Trustee/Officer agrees to notify the Company of any changes to the Plan itself that will alter the information in this Pension Plan Verification.

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For new insurance policies/annuity contracts and for existing life insurance policies in states requiring that insurable interest exist on the transfer of issued policies, I/we agree that the beneficial interests under the Plan are now, can and will be established only for individuals who are related to and/or have a substantial interest in the Insured/Annuitant/Proposed Insured by blood or law or hold a lawful, substantial economic interest in the continued life of the Insured/Annuitant/Proposed Insured.

SIGNATURES - (Each signer indicated in Question 6 must sign below.)

The signature(s) below certify the information provided and agreed to on this Verification is true and accurate and that the Plan is validly executed and in full force and effect.

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

Signature of Plan Administrator/Trustee/Officer X	Name and Title (please print)	Date (mm/dd/yyyy) / /
Signature of Plan Administrator/Trustee/Officer X	Name and Title (please print)	Date (mm/dd/yyyy) / /
Signature of Plan Administrator/Trustee/Officer X	Name and Title (please print)	Date (mm/dd/yyyy) / /
Signature of Plan Administrator/Trustee/Officer X	Name and Title (please print)	Date (mm/dd/yyyy) / /

NOTE: Please be advised that the Company reserves the right to request and receive a copy of the Plan documents, if it is determined that it is necessary to do so. Prior to payment of death benefit proceeds, the Company may also require proof that the Plan is in full force and effect.