

Beneficiary Change Request

**Mail or fax completed form to:**

PO Box 305027, Nashville, TN 37230-5027
Fax: 800 351 0603

Contact us:

Customer Contact Center – Tel: 877 462 8992

Athene Annuity and Life Company

7700 Mills Civic Parkway, West Des Moines, IA 50266

Athene Life Insurance Company of New York

69 Lydecker Street, Nyack, New York 10960

INSTRUCTIONS

Use this form to make changes to your beneficiary designation.

- To expedite the processing of your request, all pages must be completed and returned.
- Use percentages in your designation. All proceeds must total 100%. If no percentages are listed, proceeds will be divided equally.
- If you designate a class of beneficiaries (such as Children), list the full names and relationships of the known beneficiaries of that class. Notify us of any changes to that class of beneficiaries.
- Per Stirpes is a common way of distributing proceeds where if one or more of your beneficiaries has died his or her children share equally in his or her share (also known as By Right of Representation). To distribute proceeds per stirpes, check the appropriate box for each beneficiary.
- Contingent Beneficiaries will receive death benefit proceeds in the event the Primary Beneficiaries predecease the insured/annuitant and if those designations did not include per stirpes.
- If the owner is a Pension Plan, submit a Pension Plan Verification Form (17982), if you have not already done so.
- If the owner is a company, provide a Corporate Resolution or similar document that lists all of the officers and/or individuals authorized to sign on behalf of the company, if you have not already done so.
- If the owner is a Trust, submit a Trust Verification Request Form (16541), if you have not already done so. If you are designating a Trust as your beneficiary, signing as a Trustee, or if there have been changes to the Trust, please submit an updated Trust Verification Form (16541).

NOTE: For life policies with supplemental riders that allow for separate beneficiary designations, complete a Beneficiary Change Request for the Indexed Survivorship Universal Life Supplemental Insured Rider (Form 18185) to make changes to those beneficiaries. If you are making a change to the beneficiary designation on your supplemental rider, be aware those changes apply to LIFE POLICIES only.

1. OWNER INFORMATION

Individual, Trustee or Company Name				
If Trust, list Trust Name and Trust Date			Email Address	
Policy Number(s)			<input type="checkbox"/> Address Change Requested	
Mailing Address	City	State	Zip	Country
Street Address (REQUIRED if mailing address is a PO Box)	City	State	Zip	Country
Social Security / Tax Identification Number	Date of Birth (mm/dd/yy) / /		Personal Phone () -	

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2. PRIMARY BENEFICIARY(IES) (Required Information - If this section is blank we will be unable to process your request.)

To list additional Primary Beneficiaries, you may copy this page, mark the checkbox at the bottom of the page and return. You may also use additional blank pages labeled "Primary Beneficiaries". Each blank page must be signed by the Owner and dated, labeled with the word "Attachment" and include beneficiary information and policy/contract numbers.

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

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

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

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

If you need more space and have attached additional sheets to your form, check this box ☐

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3. CONTINGENT BENEFICIARY(IES)

To list additional Contingent Beneficiaries, you may copy this page, mark the checkbox at the bottom of the page and return. You may also use additional blank pages labeled "Contingent Beneficiaries". Each blank page must be signed by the Owner and dated, labeled with the word "Attachment" and include beneficiary information and policy/contract numbers.

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

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

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

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

If you need more space and have attached additional sheets to your form, check this box ☐

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4. YOUR CONFIRMATION

By signing below:

- I acknowledge this request is subject to the provisions and conditions of my policy/contract(s) and the company may request additional information in order for my request to be processed.
- I understand by submitting this document, I revoke any existing beneficiary designations and settlement agreement and request the company change the beneficiary for the listed policy/contract(s).

Owner Signature X	Date (mm/dd/yy) / /
Owner Title (if Trust or Corporation)	
Joint Owner Signature (if applicable) X	Date (mm/dd/yy) / /
Other Required Signatures (Irrevocable Beneficiaries, if any) X	Date (mm/dd/yy) / /

If you are signing on behalf of the owner, print your name and provide your signature below. Check the box that applies to the capacity in which you are signing. If you have not already done so, provide your Power of Attorney, Conservatorship, or Guardianship documents to verify you are authorized to act on behalf of the owner.

☐ Conservator ☐ Guardian ☐ Power of Attorney

Printed Name	
Signature X	Date (mm/dd/yy) / /
Witness Signature (Required Only in Massachusetts) X	Date (mm/dd/yy) / /

5. SPOUSAL CONSENT

If you live in a Community Property State (AZ, CA, ID, LA, NM, NV, TX, WA and WI), we are required to have Spousal Consent to make beneficiary changes to your policy/contract(s). This form will be returned if this section is not complete.

☐ **If you do not have a spouse, or if your spouse is deceased, check this box.**

By signing this form, I consent to the designation of the beneficiary(ies) listed above. I understand and agree:

- The effect of this designation is to cause some or all of my spouse's death benefit to be paid to a beneficiary other than me;
- Each beneficiary designation is valid; and
- My consent is irrevocable unless my spouse revokes the beneficiary designation(s).

Spouse Signature X	Date (mm/dd/yy) / /
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We appreciate your business and are committed to providing you with accurate and caring service. If you have any questions or need additional information, contact your Insurance Professional or our Customer Contact Center.