**Policy Number(s):** _____

| Claimant's Statement for Death Benefit | | |
|---|---|---|
| Name of Insured: | | |
| Address of Insured: | | |
| Social Security Number: | Date of Birth: | Date of Death |
| Cause of Death: | | |
| Did insured have multiple policies with our company or any of its predecessors? ☐ Yes ☐ No ☐ Don't Know | | |

**AUTHORIZATION:** I hereby authorize any insurance company, hospital, clinic, physician, surgeon, employer or practitioner to furnish to any claims representative of Athene Annuity & Life Assurance Company, Greenville, South Carolina, or its representative, any and all information concerning any illness or injury the insured may have suffered and copies of all hospital or medical records, including all confidential HIV, communicable disease, alcohol or drug abuse, and mental health information, so the same may be included as part of the Claim submitted to the Company. A reproduced copy of this authorization shall be considered as effective and valid as the original.

**BENEFICIARY INFORMATION:** Complete for each beneficiary. Use back of this form if additional space is needed.

_____ _____
Printed Name of Beneficiary Social Security Number

X _____ _____
Signature Date

Address _____
Street City State Zip

_____ _____ _____
Telephone Number Date of Birth Relationship to Deceased

_____ X _____
Printed Name of Witness Signature of Witness

_____ _____
Printed Name of Additional Beneficiary Social Security Number

X _____ _____
Signature Date

Address _____
Street City State Zip

_____ _____ _____
Telephone Number Date of Birth Relationship to Deceased

_____ X _____
Printed Name of Witness Signature of Witness