AMERICAN EQUITY INVESTMENT LIFE INSURANCE COMPANY™
P.O. Box 10343
Des Moines, IA 50306
888-221-1234
client.american-equity.com
Fax 515-226-3129

Lifetime Income Benefit Wellbeing Request Form

Contract Number: _____ Contract Owner(s) Name: _____

Spouse's Name (if Joint Life Payout selected): _____

PLEASE NOTE: This form must be completed and returned to us prior to the deadline stated in your notification letter in order for Wellbeing Benefits to continue for the entire Enhanced Lifetime Income Benefit period.

Physician's Statement

Physician's Name: _____ License Number: _____
(Please Print)

Physician's Address: _____ _____ _____
Street City, State Zip Code

Physician's Phone Number: _____

As a duly licensed physician, I hereby certify that _____
Patient's Name
is unable to perform at least two of the basic Activities of Daily Living without substantial assistance at this time. By signing below I certify that at this time, the Patient named above is unable to perform at least two of the basic activities of daily living I have marked:

☐ Bathing ☐ Dressing ☐ Eating

☐ Continence ☐ Toileting ☐ Transferring

Additional remarks: _____

_____

_____

_____

Physician's Signature: _____ Date: _____

Owner Acknowledgement and Authorization

By signing this form you authorize an American Equity representative to phone the authorized physician to confirm eligibility and acknowledge you or your spouse, if applicable, meet this eligibility requirement for the Lifetime Income Benefit and Wellbeing Rider. By signing this form you also agree to cooperate if we choose to use an independent licensed doctor, at our expense, to assist us in the assessment of whether eligibility requirements have been met.

Owner's Signature: _____ Date: _____

Spouse's Signature or
Joint Owner's Signature (if applicable): _____ Date: _____