American Equity Investment Life Insurance Company®
P.O. Box 10343, Des Moines, IA 50306-0343
O/N Address: 6000 Westown Parkway, West Des Moines, IA 50266
Phone: 888-221-1234 • Fax: 515-226-3129
www.american-equity.com • Email: service@american-equity.com

Lifetime Income Benefit Wellbeing Request Form

Print Reset

Contract Number(s):			Trust or Entity Name:	
Owner's Name				
(Prefix)	Legal Name (First)	(Middle)	(Last)	(Suffix)
Spouse's Name *(if Joint Life Payout selected)*				
(Prefix)	Legal Name (First)	(Middle)	(Last)	(Suffix)

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

American Equity Investment Life Insurance Company®
P.O. Box 10343, Des Moines, IA 50306-0343
O/N Address: 6000 Westown Parkway, West Des Moines, IA 50266
Phone: 888-221-1234 • Fax: 515-226-3129
www.american-equity.com • Email: service@american-equity.com

Lifetime Income Benefit Wellbeing Request Form

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

*If you are signing on behalf of the owner, please indicate the capacity in which you are signing:

☐ Trustee ☐ Attorney-in-Fact ☐ Conservator/guardian ☐ Other: _____

_____ _____

Joint Owner's Signature* Date

*If you are signing on behalf of the joint owner, please indicate the capacity in which you are signing:

☐ Trustee ☐ Attorney-in-Fact ☐ Conservator/guardian ☐ Other: _____