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American Equity Investment Life Insurance Company of New York

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Nursing Care Verification

Section 1 - Patient Information

Contract Number(s):	
Owner's (Patient's) Name:	Date of Birth:

Section 2 - Instructions

The Nursing Care Rider (NCR) attached to your annuity contract allows you to take a free withdrawal from your contract value if, after your first contract anniversary, you are confined to a qualified nursing facility for at least 90 consecutive days, at the recommendation of a qualified physician. To activate your NCR, please complete this form, have an authorized employee of the qualified nursing care facility sign under section three, and have your physician sign under section four. *Any withdrawal taken prior to age 59 ½ is subject to a 10% IRS penalty.*

Section 3 - Qualified Nursing Care Facility

This section should be completed by an authorized employee of the qualified nursing care facility.

Name of facility: _____

Phone number of facility: _____

Date patient entered facility: _____

Is the patient currently living in the facility? ❑ Yes ❑ No If no, date patient left facility: _____

Please identify the type of facility:

❑ **Hospice care facility:** a facility that (1) provides a formal, inpatient program, directed by a qualified physician, for terminally ill patients whose life expectancy is less than six months; and (2) is licensed, certified, or registered as such in accordance with state laws.

❑ **Hospital:** a facility that (1) provides inpatient care for the treatment of sick or injured persons; (2) provides 24-hour-a-day nursing care by, or supervised by, a registered nurse (R.N.); (3) is supervised by a staff of licensed physicians; and (4) has medical, diagnostic, and major surgical capabilities or access to such capabilities.

❑ **Intermediate care facility:** a facility that (1) provides 24-hour-a-day nursing care by, or supervised by, a registered nurse or licensed practical nurse; and (2) keeps a daily medical record of each patient.

The following facilities are not qualified nursing care facilities under the NCR: (1) drug or alcohol treatment centers; (2) homes for the aged or mentally ill; (3) community living centers; (4) facilities that primarily provide domiciliary, residency or retirement care; or (5) facilities owned or operated by a member of the annuitant's immediate family.

By signing below, I certify that:

1. I am authorized to make the following statements on behalf of the facility identified above;
2. The facility identified above is not owned nor operated by an immediate family member of the patient; and
3. The information provided in this section is true to the best of my knowledge.

Signature: _____ Date: _____

Printed Name: _____ Title: _____

Section 4 - Physician Certification

By signing below, I certify that:

1. I am currently licensed (either MD or DO) to practice medicine in the United States;
2. The person named as the patient in section one is my patient (referred to in this section as "my patient");
3. I am not related, by blood or marriage, to my patient;
4. My patient entered the facility identified in section three upon my recommendation.; and
5. All information provided on this form is true to the best of my knowledge.

Physician's Signature: _____ Date: _____

Physician's Printed Name: _____ Phone Number: _____