American Healthcare REIT

ACCOUNT UPDATE FORM

American Healthcare REIT, Inc.

Account #: ______________________

Complete this form and return to address below.

Regular Mail:	**American Healthcare REIT, Inc.** **c/o DST Systems, Inc.** **PO Box 219386** **Kansas City, MO 64121-9386**
Overnight Address:	**American Healthcare REIT, Inc.** **c/o DST Systems, Inc.** **330 W 9th Street, Suite 219386** **Kansas City, MO 64105-1514**
Fax:	**833.674.0762**

INSTRUCTIONS

Please complete all applicable sections depending upon your account change(s). Check all boxes that apply.

☐ **CHANGE OF ADDRESS** (Sections 1, 2 & 5)

☐ **CHANGE OF REPRESENTATIVE OR BROKER-DEALER** (Sections 1, 3 & 5)

☐ **DISTRIBUTION INSTRUCTIONS** (Sections 1, 4 & 5)

1.) CURRENT ACCOUNT OWNER INFORMATION

ACCOUNT NAME(S)

TELEPHONE NUMBER ____ – ____ – ____

REGISTERED OWNER'S SSN ____ – ____ – ____ OR REGISTERED OWNER'S TAX ID# ____ – ____

2.) CHANGE OF ADDRESS

If you are providing an address outside of the U.S., please complete the following by indicating citizenship status (REQUIRED):

☐ U.S. Citizen ☐ Resident Alien ☐ Non-Resident Alien

If non-resident alien, investor must submit the appropriate W-8 form (W-8BEN, W-8ECI, W8EXP OR W8IMY).

Please indicate whether the change of address pertains to the:

☐ Mailing Address or ☐ Residential Street Address (No PO Boxes)

ADDRESS

CITY

STATE

ZIP CODE

NEW HOME TELEPHONE NUMBER ____ – ____ – ____

NEW BUSINESS TELEPHONE NUMBER ____ – ____ – ____

NEW E-MAIL ADDRESS

3.) CHANGE OF REPRESENTATIVE OR BROKER-DEALER

If the account owner chooses to change from one registered representative to another within the same broker-dealer, a signature is only required from an authorized principal of the broker-dealer. If the account owner chooses to transfer account(s) to a different broker-dealer, all registered account owners and an authorized principal from the new broker-dealer must sign. The registered representative on the account may **not** sign as the authorized principal for the broker-dealer. For custodial accounts, a Medallion Guarantee stamp or appropriate authorization from the custodian is required in section 5.

NEW FIRM NAME

NEW REGISTERED REPRESENTATIVE

REPRESENTATIVE NUMBER

BRANCH ADDRESS

CITY

STATE

ZIP CODE

TELEPHONE NUMBER ____ – ____ – ____

FAX NUMBER ____ – ____ – ____

PRINT NAME OF AUTHORIZED PRINCIPAL REQUIRED

SIGNATURE BY AUTHORIZED PRINCIPAL REQUIRED

X

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4.) DISTRIBUTION INSTRUCTION

Investor Services must be in receipt of this form 30 days prior to declaration of the distribution. This authorization will supersede any previous distribution instructions.

☐ **Cash** ________ **%**

☐ **DRP** ________ **%** (Distribution Reinvestment Plan)

TOTAL = 100%

PLEASE CHECK ALL THAT APPLY:

☐ **Elect Direct Deposit/Change Banking Information**

☐ **Discontinue Direct Deposit**

☐ **Elect Distribution Reinvestment Plan**

☐ **Discontinue Distribution Reinvestment Plan**

☐ **Mail Distribution Checks to Address of Record**

☐ **Mail Distribution Checks to Financial Institution**

- Direct Deposit is not available for investments made through brokerage or custodial held accounts.
- When initiating Direct Deposit, you are required to submit either a voided check or letter from the designated financial institution which verifies the direct deposit instructions.
- Changes to custodial accounts require a Medallion Guarantee stamp or appropriate authorization from the custodian.

By electing to have my distributions reinvested in the Distribution Reinvestment Plan ("DRIP"):

- I hereby appoint American Healthcare REIT, Inc. (the "Company") (or any designee or successor), acting as DRIP Administrator as my agent to receive cash distributions that may hereafter become payable to me on shares of the Company's Class T or Class I common stock, $0.01 par value per share (the "Common Stock") registered in my name as set forth below, and authorize the Company to apply such distributions to the purchase of full shares and fractional interests in the same class of shares of the Common stock as indicated above.
- I understand that the purchases will be made under the terms and conditions of the DRIP as described in the Prospectus and that I may revoke this authorization at any time by notifying the DRIP Administrator, in writing, of my desire to terminate my participation.

FINANCIAL INSTITUTION INFORMATION

NAME OF FINANCIAL INSTITUTION

ACCOUNT NUMBER

MAILING ADDRESS

CITY

STATE

ZIP CODE

DIRECT DEPOSIT INFORMATION

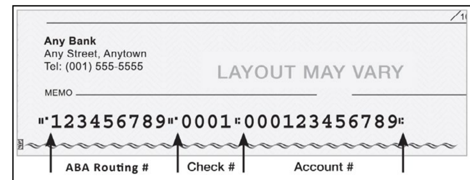
The above referenced investment is authorized to deposit my (our) distribution directly into the account specified on this form. The authority will remain in force until I (we) have given written notice that I (we) have terminated it, or until the above referenced investment has notified me (us) that this deposit service has been terminated. In the event that the above referenced investment deposits funds erroneously into my (our) account, it is authorized to debit my (our) account for an amount not to exceed the amount of the erroneous deposit.

Select One:

☐ Checking Account (voided check **REQUIRED**)

☐ Savings Account

9-DIGIT ROUTING/ABA NUMBER (see example)



5.) SIGNATURES

All Registered Account Owners are Required to Sign

ACCOUNT OWNER SIGNATURE

X

DATE

JOINT ACCOUNT OWNER OR AUTHORIZED SIGNATURE OF CUSTODIAN

X

DATE

CUSTODIAL ACCOUNTS REQUIRE A MEDALLION GUARANTEE STAMP OR APPROVAL FROM THE CUSTODIAN