

Application for Insurance Instructions and Checklist

Ameritas Life Insurance Corp. ("Company") P.O. Box 81889, Lincoln, NE 68501 / 800-745-1112, Fax 402-467-7335

1. The Notice of Insurance Information Practices must be given to the client prior to completion of the application.
2. The proposed insured, spouse, and applicant, if any, must sign the form where indicated.
3. We cannot accept life insurance applications for minors younger than fifteen (15) days old.
4. ALL questions must be answered. Changes to answers must be initialed and dated by the proposed insured and the applicant, if the applicant is not the proposed insured. Do not use correction fluid or correction tape to change any answers, or fill in any blank information after the application has been signed.
5. Whole Life contracts: if dividend option Accumulate with Interest is selected, an IRS Form W-9 must be returned to the client service office.
6. **FATCA requires: (a) IRS Form W-9 for all US entity policy owners, (b) IRS Form W-8BEN for all foreign individual policy owners, and (c) the appropriate IRS Form from the W-8 series for foreign entity policy owners. *****
7. If a life insurance or annuity contract is being replaced, you must follow appropriate replacement procedures.

Traditional & Universal Life

Variable Universal Life

Application Checklist

| Application Checklist | | | Included? | |
|---------------------------|--------------|---|------------------------------|-----------------------------|
| Provide to Insured | UN 92 NI | Notice of Insurance Practices | <input type="checkbox"/> Yes | N/A |
| Always Submit | UN 92 PI | Personal Information | <input type="checkbox"/> Yes | N/A |
| Submit as Required | UN 92 PD | Universal Life/Traditional Life Policy Details | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | UN 92 IUL | Supplemental Application for Index UL | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | UN 92 PDV | Variable Universal Life Policy Details | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | UN 92 IAV | Investment Advisory Agreement | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | UN 92 APEP | Excel Performance VUL Allocation of Premiums | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | UN 92 FI LHQ | Financial Information and Lifestyle and Health* Questionnaire | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Always Submit | UN 92 AG | Agreement | <input type="checkbox"/> Yes | N/A |
| | UN 92 AU | Authorization | <input type="checkbox"/> Yes | N/A |
| | UN 92 PS | Producer's Statement | <input type="checkbox"/> Yes | N/A |
| | UN 92 CR | Conditional Receipt** | <input type="checkbox"/> Yes | N/A |
| Always Submit | W-9*** | TIN cert. (if WL Div. Option = Accum. At Int. or US entity policy owner) – See #5 and #6 above | <input type="checkbox"/> Yes | N/A |
| | W-8 BEN*** | TIN cert. Foreign Status policy owner (individual – See #6 above) | <input type="checkbox"/> Yes | N/A |

* If the coverage requested is within the Company's nonmedical limits, no other application forms are required. If the coverage requested exceeds our published nonmedical limits, a medical or paramedical examination should be obtained.

** A Conditional Receipt is given to the premium payor whenever full initial premium is collected. Do not accept premium if the amount of life insurance requested exceeds a death benefit of \$1,000,000. Also, premium should not be accepted if the proposed insured is age 75 or older, or has been treated for heart disease, diabetes, stroke, or cancer within the past 12 months, or has been admitted to a medical facility within the past 90 days. Premium payments must be made by personal or business check, or initial draft Electronic Fund Transfer (EFT) authorization only. No cash, money orders, traveler's checks or bank checks are permitted.

*** For further information and instructions, please refer to <http://www.irs.gov/Businesses/Corporations/FATCA-Related-Forms>.

Securities offered through affiliate Ameritas Investment Corp., member FINRA and SIPC.

Application for Insurance Notice of Insurance Information Practices

Ameritas Life Insurance Corp. ("Company") P.O. Box 81889, Lincoln, NE 68501 / 800-745-1112, Fax 402-467-7335

To issue an insurance policy we need to obtain information about you and any other persons proposed for insurance. Some of that information will come from you and some will come from other sources. We may obtain information relating to any proposed insured's mental and physical health, general character and reputation, habits, finances, occupation, other insurance coverage, or participation in hazardous activities.

This information may be obtained from physicians, medical professionals, hospitals, clinics or other medical care institutions, or from MIB, Inc. ("MIB"), public records, consumer reporting agencies, financial sources, other insurance companies, producers, friends, neighbors and associates. We may obtain information through exchanges or correspondence, by telephone or by personal contact.

Information regarding your insurability or claims will be treated as confidential. The Company or its reinsurers may, however, make a brief report thereon to MIB, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file. Upon receipt of a request from you, the MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the MIB's information office is 50 Braintree Hill, Suite 400, Braintree, Massachusetts 02184-8734; telephone number (866) 692-6901 (TTY 866-346-3642); website address www.mib.com. The Company or its reinsurers may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

Furthermore, as part of our procedure for processing your insurance application, an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends, associates, or others with whom you are acquainted.

This inquiry and any subsequent investigative consumer report update which may also be requested includes information as to your character, general reputation, personal characteristics, and mode of living.

You have the right to be personally interviewed if we order an investigative consumer report. Please notify our producer if this is your wish. You are also entitled to receive a copy of the investigative consumer report whether or not an interview is conducted. You also have the right to make a written request within a reasonable period of time to receive additional, detailed information about the nature and scope of this investigation.

To reduce costs and offer insurance coverage at the lowest possible premium, the Company may also use a Personal History Interview. A specially trained interviewer may call to discuss information contained in your application or to ask questions related to the underwriting of your insurance. We will attempt to conduct this telephone interview at your convenience and at a number you designate.

In the event of an adverse underwriting decision, upon written request, we will provide you with the specific reason in writing for that adverse underwriting decision.

As a general practice, we will not disclose personal information about you to anyone else without your consent, unless a legitimate business need exists or disclosure is required or permitted by law. A description of the circumstances under which information about you might be disclosed without your authorization will be sent to you upon request.

You have a right of access to personal information we maintain in our files and to request correction, amendment, or deletion of any information you believe to be incorrect. You may request a description of established procedures which will allow access to and correction of such personal information.

If you wish to have a more detailed explanation of our information practices, including your rights of access to and correction of personal information, please contact the Underwriting Department at the above address.

DETACH AND DELIVER TO PROPOSED INSURED BEFORE COMPLETION OF THE APPLICATION

1. Proposed Insured:

- a) Name: _____
- b) Date of Birth: _____ c) Sex: Male Female
- d) Place of Birth: _____
- e) Social Security/Tax ID No.: _____
- f) Driver's License or other Government issued picture ID: _____ State: _____
- g) Home Address: _____
City: _____ State: _____ ZIP: _____
- h) Years at this Address: _____
- i) Tel. (Home): _____
(Business): _____
Fax: _____
E-mail: _____
Best time to call: _____ at: Business Home
In the event you are not available when our interviewer calls, may we speak with your spouse? Yes No
- j) Residency Status: U.S. Resident Other: _____
- k) Are you a U.S. Citizen: Yes No
If "No," provide the following:
Copy of valid Passport and Visa
Citizenship: _____
Visa Type: _____ Visa #: _____
Number of years residing in U.S.: _____
- l) Employer Name: _____
Address: _____
City: _____ State: _____ ZIP: _____
- m) Occupation: _____ Years: _____
- n) Duties: _____
- o) Have you been actively at work on a full-time basis, performing your normal duties for at least 30 hours per week for the past 3 months with no absences totaling 5 consecutive days or more due to illness or accident: Yes No
If "No," explain (attach extra sheet if needed):

2. Owner Information:

(complete only if Owner is other than Proposed Insured)

- a) Individual b) Trust (provide copy) c) Partnership
- d) Corporation: County of Incorporation: _____
(complete Form UN 1166)
- e) Full Name: _____
- f) Relationship to Proposed Insured(s): _____
- g) Trustee(s) Name: _____
- h) Date of Birth or Date of Trust: _____
- i) Social Security/Tax ID No.: _____
- j) Driver's License or other Government issued picture ID: _____ State: _____
- k) Address: _____

City: _____ State: _____ ZIP: _____
- l) Tel. (Home): _____ (Business): _____
Fax: _____ E-mail: _____
- m) Residency Status: U.S. Resident Other: _____
- n) Are you a U.S. Citizen: Yes No
If "No," provide the following:
Copy of valid Passport and Visa
Citizenship: _____
Visa Type: _____ Visa #: _____
Number of years residing in U.S.: _____
- o) Multiple Ownership (indicate type):
 Joint with Survivorship
 Tenants in Common
- p) Successor Owner:
Name: _____
Social Security/Tax ID No.: _____

3. Beneficiary Information: (subject to change by Owner)

- a) Primary Beneficiary: _____

Address: _____
City: _____ State: _____ ZIP: _____
Relationship to Proposed Insured: _____
Social Security/Tax ID: _____
Date of Birth or Date of Trust: _____

- b) Contingent Beneficiary: _____

Address: _____
City: _____ State: _____ ZIP: _____
Relationship to Proposed Insured: _____
Social Security/Tax ID: _____
Date of Birth or Date of Trust: _____

Application for Insurance Policy Details for Universal Life / Traditional Life

Ameritas Life Insurance Corp. ("Company") P.O. Box 81889, Lincoln, NE 68501 / 800-745-1112, Fax 402-467-7335

- 1. Universal Life:** a) Specified Amount (*base only*): \$ _____ Plan of Insurance: _____
- b) Index UL: Complete Supplement for Index UL Products.
- c) Death Benefit Option: Option A (*Specified Amount*)
 Option B (*Specified Amount plus Account Value*)
 Option C (*Specified Amount plus Return of Premium minus Partial Withdrawals*)
- d) Life Insurance Qualification Test: GPT (*Guideline Premium Test*) CVAT (*Cash Value Accumulation Test*)
- e) Planned Periodic Premium (*modal*): \$ _____ Additional First-Year Premium (*lump-sum deposits*): \$ _____
- f) Single Life Supplementary Benefits:
- | | |
|---|--|
| <input type="checkbox"/> Accidental Death Benefit Rider . . . \$ _____ | <input type="checkbox"/> Supplemental Coverage Rider \$ _____ |
| <input type="checkbox"/> Accounting Benefit Rider \$ _____ | <input type="checkbox"/> Total Disability Benefit Rider \$ _____ |
| <input type="checkbox"/> Guaranteed Insurability Rider \$ _____ | <input type="checkbox"/> Waiver of Monthly Deduction Rider |
| <input type="checkbox"/> Scheduled Increase Rider % _____ | <input type="checkbox"/> Other: _____ |

- 2. Term Life:** a) Specified Amount: \$ _____
- b) Plan of Insurance: Term 1 Term 10 Term 15 Term 20 Term 30 Other: _____
- c) Supplementary Benefits: Accidental Death Benefit Rider: \$ _____
 Waiver of Premium Rider Other: _____

- 3. Whole Life:** a) Specified Amount: \$ _____ Plan of Insurance: _____
- b) Dividend Option: Paid-Up Additions Cash Accumulate at Interest (*complete IRS Form W9*)
 Reduce Premium (*not on monthly modes*) One-Year Term
- c) Nonforfeiture Option: Extended Term Insurance Reduce Paid-Up Automatic Premium Loan
- d) Supplementary Benefits:
- | | |
|---|---|
| <input type="checkbox"/> Accidental Death Benefit Rider . . . \$ _____ | <input type="checkbox"/> Guaranteed Insurability Rider \$ _____ |
| <input type="checkbox"/> Flexible Paid-Up Rider: | <input type="checkbox"/> Level Term Rider \$ _____ |
| <input type="checkbox"/> Single Premium \$ _____ | <input type="checkbox"/> 10 yr <input type="checkbox"/> 15 yr <input type="checkbox"/> 20 yr <input type="checkbox"/> 30 yr |
| <input type="checkbox"/> Scheduled Premium \$ _____ | <input type="checkbox"/> One-Year Term Rider \$ _____ |
| Premium Frequency: <input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual | <input type="checkbox"/> Term Paid-Up Rider (TPL) \$ _____ |
| <input type="checkbox"/> Quarterly <input type="checkbox"/> Electronic Fund Transfer (<i>complete EFT form</i>) | <input type="checkbox"/> Total Disability Benefit Rider \$ _____ |
| <input type="checkbox"/> Salary Allotment <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Waiver of Premium Rider |
| | <input type="checkbox"/> Other: _____ |

- 4. Payor:** a) Payor Information: Insured Owner Other: (*provide details*)
- Name: _____ Relationship: _____
- Address: _____ Purpose: _____
- b) Send Premium Notices to: Residence Business
- c) Premium Frequency: Annual Semi-Annual Quarterly
 Electronic Fund Transfer (*complete EFT form*) Salary Allotment Other: _____
- d) Has any premium been given in connection with this application? Yes \$ _____ (*complete Conditional Receipt*) No
If this is a request for a **one-time** initial draft of the direct modal premium, check here and complete EFT form.

Application for Insurance Financial Information / Lifestyle and Health Questionnaire

Ameritas Life Insurance Corp. ("Company") P.O. Box 81889, Lincoln, NE 68501 / 800-745-1112, Fax 402-467-7335

Financial Information

1. Financial Questions:

- a) Gross annual earned income. \$ _____
(salary, commissions, bonuses, etc.)
- b) Gross annual unearned income. \$ _____
(dividend, interest, net real estate income, etc.)

2. Source of Premiums: (check one or more)

- Current Income Cash Savings
- Other: _____

3. Existing and Pending Insurance - Proposed Insured:

- a) Total insurance in force on the Proposed Insured. \$ _____
- b) Total insurance currently pending with all companies, including this application \$ _____

4. Existing Insurance (Replacement):

- a) Do you have any existing life insurance policies or annuity contracts? (if "Yes," complete a Replacement Notice if required by State Law). . . . Yes No
- b) Will any life insurance policy or annuity contract presently in force with this or any other company be discontinued, reduced, changed, or replaced if insurance now applied for is issued? (if "Yes," give details) Yes No
Company: _____
Policy No.: _____ Amount: \$ _____
Date: _____ Type of Policy: _____

5. Insurance Producer's Replacement Statement:

- a) To the best of your knowledge, does the applicant have any existing insurance policies or annuity contracts? Yes No
- b) To the best of your knowledge, does the policy applied for involve replacement, in whole or in part, of any existing life insurance, annuity, disability income or overhead expense insurance, or any other accident and sickness insurance? (if "Yes," give details) . . . Yes No
Company: _____
Policy No.: _____
- c) Will a policy loan on one or more policies be utilized to pay any portion of the initial premium or deposit on the policy applied for? Yes No
(if "Yes," give policy number(s) involved) _____

Lifestyle Questions (please provide details for "Yes" answers)

- 1. Have you used tobacco or nicotine products in any form within the last five years? (in Details, provide dates and type; cigarettes, e-cigarettes, cigars, cigarillos, a pipe, chewing tobacco, nicotine patches, gum, etc.) Yes No
- 2. Have you ever applied for insurance or reinstatement which has been: declined, postponed, rated, modified; or had any such insurance canceled or a renewal premium refused? (in Details, provide date, reason and company name) Yes No
- 3. Have you ever made any flights as: a pilot, student pilot, or crew member of any aircraft? (if "Yes," complete Aviation Questionnaire) Yes No
- 4. Have you engaged in or plan to engage in any form of: motorized racing, scuba diving, parachuting/skydiving, martial arts, mountain climbing or any other hazardous sport? (if "Yes," complete appropriate form(s)) Yes No

Health Questions (please provide details for "Yes" answers)

- 1. a) Height: ___ ft. ____ in. b) Weight: _____ lbs.
- c) Has your weight changed by more than 10lbs. in the last twelve months? If yes, list amount gained or lost and reason for the change in weight. Yes No
- 2. Within the past twenty years, have you been medically evaluated for, diagnosed with or treated for:
 - a) Coronary artery disease, heart attack, heart failure, chest pain, heart valve disease, irregular heartbeat, heart murmur, stroke, aneurysm or other disorder of the heart or blood vessels? Yes No
 - b) Diabetes, elevated blood sugar, thyroid, pituitary, adrenal or other endocrine (glandular) disorders? Yes No
 - c) Cancer, tumor, mass, polyp or cyst? Yes No
 - d) Liver or kidney disorder? Yes No
 - e) Major depressive disorder, bipolar, schizophrenia or other mental disorder? Yes No
- 3. Within the past 10 years, have you ever:
 - a) Used marijuana, cocaine, heroin, barbiturates, tranquilizers, hallucinogens, amphetamines, narcotics or any other drug, except as legally prescribed by a physician? . Yes No
 - b) Consumed alcoholic beverages? Yes No
If yes, specify extent: _____
- 4. Within the past twenty years, have you been diagnosed by a licensed medical professional as having Acquired Immune Deficiency Syndrome (AIDS) or tested positive for Human Immunodeficiency Virus (HIV)? Yes No
- 5. a) Name and address of personal or attending physician:

b) Telephone: _____
c) Date last consulted: _____
Reason and any medication/treatment given:

d) List any medications (prescription or nonprescription) you are currently taking:

For each "Yes" answer, give details. (Identify: question number, diagnosis, dates, duration, treatment, names and addresses of all attending physicians and medical facilities and attach additional sheet, if needed)

Application for Insurance Agreement

Ameritas Life Insurance Corp. ("Company") P.O. Box 81889, Lincoln, NE 68501 / 800-745-1112, Fax 402-467-7335

Agreement

The undersigned represent that their statements in this application and Part II, if such Part II is required by the Company, are true and complete to the best of their knowledge and belief. It is agreed that:

- (a) the only statements to be considered as the basis of the policy are those contained in the application or in any amendment to the application;
- (b) any prepayment made with this application will be subject to the provisions of the CONDITIONAL RECEIPT;
- (c) **if there is no prepayment made with this application, the policy will not take effect until:**
 - (1) **the first premium is paid during the lifetime of the proposed insured and while his/her health and the facts and other conditions affecting insurability remain as described in this application and Part II, if required; and**
 - (2) **the policy is delivered to the Owner;**
- (d) no one except the President, a Vice President, the Secretary, or an Assistant Secretary can make, alter or discharge contracts or waive the Company's rights or requirements; and
- (e) this application was signed and dated in the state indicated.

If applying for an indeterminate premium plan:

- (a) the premium for such plan is guaranteed for the initial guarantee period, and after such period, the current annual premium is not guaranteed and may change; and
- (b) the premium will never exceed the specified maximum.

Fraud Notice

Any person who knowingly or with intent to defraud; submits an application or files a claim containing false, incomplete or misleading information; is guilty of a crime and may be subject to fines and criminal penalties, including imprisonment. In addition, insurance benefits may be denied if false information provided by an applicant is materially related to a claim.

Dated at: _____
City State Month Day Year

Print or Type Proposed Insured Name

X _____
Signature of Proposed Insured
(or Personal Representative if Proposed Insured is a minor)

Print or Type Owner if not Proposed Insured

X _____
Signature of Owner if not Proposed Insured

Print or Type Insurance Producer Name

Producer No. Sit. Code % Split

X _____
Signature of Insurance Producer Producer State Lic. No.

Print or Type Insurance Producer Name

Producer No. Sit. Code % Split

X _____
Signature of Insurance Producer Producer State Lic. No.

Print or Type Insurance Producer Name

Producer No. Sit. Code % Split

X _____
Signature of Insurance Producer Producer State Lic. No.

Agency Name Agency No.

Application for Insurance Authorization

Ameritas Life Insurance Corp. ("Company") P.O. Box 81889, Lincoln, NE 68501 / 800-745-1112, Fax 402-467-7335

Authorization to Obtain and Disclose Information

Proposed Insured/Patient (please print): _____ Date of Birth: _____

I authorize any health care providers, pharmacy benefit manager, hospitals, insurers, consumer reporting agency, government agency, financial institution, and/or accounting, educational institution, or employer; having data or facts about the proposed insured's or claimant's physical or mental condition, medical care, advice, treatment, use of drugs, alcohol or tobacco, HIV, AIDS and sexually transmitted diseases, prescription drug records, financial status, education records, or employment status or other relevant data or facts about the proposed insured or claimant; including wage and earnings, or data or facts with respect to other insurance coverage; to give all data or facts to the Company, its reinsurers, or any other agent or agency acting on the Company's behalf.

I authorize MIB, Inc., and any MIB member insurer, to provide any medical or personal information that it has about me to the Company, its reinsurers or any MIB-authorized third-party administrator performing underwriting services on the Company's behalf. I also authorize the Company, its reinsurers or authorized third-party administrator, to make a brief report of my protected health information to MIB, Inc.

I authorize any physician, health care professional, hospital, clinic, medical facility, other health care provider or health plan, insurer, or other covered entity subject to HIPAA, to release and disclose my medical record without restriction pursuant to 45 CFR 164.524. I understand that my personal information, including my protected health information disclosed under this authorization, will be incorporated into and made a part of any life insurance policy(s) issued by the Company in connection with the application(s) for insurance that I have submitted to the Company. I further understand that the policy(s) will be delivered to the policy owner, which may be my employer or other party. The information included and forming a part of such policy(s), including my protected health information, may be disclosed to the policy owner.

I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization to disclose. I understand any information disclosed under this authorization may no longer be covered by the privacy provisions of HIPAA and may be subject to redisclosure. 45 CFR 164.508(c)(2)(ii). I understand I do not have to sign this authorization in order to obtain health care (treatment, payment, enrollment or eligibility for benefits). 45 CFR 164.508(c)(2)(ii). My refusal to sign this form will not adversely affect my ability to receive health care services, reimbursement for services, enrollment in a health plan or my eligibility for health benefits. 45 CFR 164.508(c)(2)(ii).

I acknowledge and agree that the above data and facts will be used to: (1) underwrite an application for coverage; (2) obtain reinsurance; (3) resolve or contest any issues of incomplete, incorrect, or misrepresented information on the application identified above which may arise during the processing or review of the application, or any other application for insurance; (4) administer coverage and claims; and (5) complete a consumer report, investigative consumer report or telephone interview about the proposed insured or claimant.

I agree that this authorization is valid for such time limit, if any, permitted by applicable law in the state where the policy is delivered or issued for delivery. I also agree that a copy is as valid as the original. I, or my authorized representative, am entitled to a copy. For purposes of collecting data or facts relating to a claim for benefits, this authorization is valid for the duration of the claim. I understand that: (1) I can revoke this authorization at any time by giving written request to the Company; (2) revoking this authorization will not affect any prior action taken by the Company in reliance upon this authorization; and (3) failing to sign, or revoking this authorization may impair the Company's ability to process my application or evaluate my claim and may be a basis for denying this application or a claim for benefits.

I acknowledge receipt of Notice of Insurance Information Practices.

Dated at: _____
City State Month Day Year

Print or Type Proposed Insured Name

Signature of Proposed Insured

Print or Type Name of Personal Representative of Proposed Insured

Signature of Personal Representative of Proposed Insured

Description of Authority of Personal Representative
(Parent, Legal Guardian, Attorney-in-Fact)
(attach documentation in support of your authority)

This Authorization complies with the HIPAA Privacy Rules.

Application for Insurance Producer's Statement

Ameritas Life Insurance Corp. ("Company") P.O. Box 81889, Lincoln, NE 68501 / 800-745-1112, Fax 402-467-7335

1. Did you receive Home Office Assistance? Yes No

Name: _____

2. Life Insurance Information

a) If proposed insured is married, indicate amount of life insurance in force on spouse: \$ _____

b) Are all of proposed insured's minor brothers and sisters insured for an equal amount? Yes No

If no, please provide details: _____

Purpose of Insurance:

c) Personal Life Insurance

Survivor Needs Spouse Insurance Education Funding Mortgage Acceleration Income Replacement

Retirement Funding Other (specify): _____

d) Estate

Charitable Gifts Estate Tax Fund Trusts for Heirs Equalization between Heirs

Other (specify): _____

3. Is the intent to fund any of this life insurance with Qualified money (i.e., IRA, Pension, 401k, etc.)? Yes No

If yes, did you give advice to use Qualified funds? Yes No

4. Underwriting Class Quoted

Tobacco Nontobacco

5. Producer Remarks

6. Producer's Certification (must be Signed and Dated)

I Certify that:

- I have reasonable grounds to believe the purchase of the policy applied for is suitable for the policy owner based on the information furnished by the proposed insured and/or policy owner in this application.
- For Variable Products a current prospectus(es) was (were) delivered to the proposed insured.
- All of the sales materials used have been approved in advance by the Company.
- I am familiar with the Guide to Market Conduct (*form ULC 16*), and the sale of this product is consistent with those guidelines.
- I have verified the accuracy of the proposed insured's and/or owner's identity.
- I certify that I have truly and accurately recorded on the application all the information supplied by the applicant.
- This application was in fact signed and dated in the state indicated.

X _____
Signature of Insurance Producer Insurance Producer Number

Print Full Name of Insurance Producer Agency Number

Application for Insurance Conditional Receipt

Ameritas Life Insurance Corp. ("Company") P.O. Box 81889, Lincoln, NE 68501 / 800-745-1112, Fax 402-467-7335

Notice to Producer and Applicant

Premium should not be accepted if the amount applied for is over \$1,000,000 or the proposed insured: (1) is age 75 or older; or (2) has been treated for heart disease, diabetes, stroke, or cancer, within the past 12 months; or (3) has been admitted to a medical facility within the past 90 days; or (4) is a foreign national.

Notice to Applicant

PLEASE READ THIS RECEIPT CAREFULLY.

Terms and Conditions

All of the terms and conditions of this receipt must be fulfilled for insurance to be in effect on the "coverage date," subject to the maximum amount limitations listed below, or no insurance will be in effect under this receipt. The "coverage date" is the date of this application or Part II of this application or medical examination or other tests required by published rules of the Company used when considering the benefits applied for, whichever date is latest.

1. Premium Payment

For Universal Life insurance, the premium payment taken with this application must be equal to or greater than the full initial premium. For any other life insurance, the premium taken with this application must be equal to the full first premium for the mode of premium and the applied for benefits. All premium checks must be made payable to the Company. Do not make checks payable to the insurance producer or present a blank check.

2. Insurability

As of the "coverage date," the Company's Underwriting Officer must find the proposed insured to be an acceptable risk at standard premium rates for the benefits applied for without an exclusion or restrictive endorsement.

3. Maximum Amount

Any liability of the Company under this and any other receipts may not exceed the lesser of: (a) the amount applied for in this application, or in the case of Universal Life insurance, the initial specified amount applied for; or (b) \$1,000,000 of insurance and \$100,000 of accidental death benefits.

4. Termination of Conditional Insurance

If insurance is provided under this receipt, it will terminate on the date the policy(ies) is/are delivered to the applicant or the date a premium refund is mailed to the payor and/or a notice is sent that the application(s) will no longer be considered on a pre-paid basis. If the applicant withdraws from consideration for coverage or refuses an offer of coverage or the application(s) is/are declined by the Company, all premiums paid in connection with the policy(ies) will be refunded and no coverage will have been provided under this receipt.

5. Limitations

- a) **The Company's Liability:** Except as limited by this receipt, the Company's liability is governed by the terms of the policy(ies) applied for.
- b) **Suicide:** If the proposed insured commits suicide while sane or insane, the Company's liability under this receipt will be limited to a refund of the premium payment submitted with the application.
- c) **Misrepresentation:** If there are any incorrect, untrue, incomplete, or omitted statement(s) of material fact in the application, any supplemental form(s), or medical questionnaire(s) that would become a part of the policy(ies), no benefit will be payable under this receipt, and this receipt will become null and void. No knowledge of any fact on the part of any producer, broker, licensed representative, medical examiner, telephone interviewer, or other person shall be considered knowledge of the Company unless such fact is stated in the application.
- d) **Other:** If any provision of this receipt is not enforceable under state law, all other terms and conditions shall continue in full force and effect.

No insurance is provided under this Conditional Receipt unless all terms and conditions of this receipt are met. This receipt is void if the payment is made by a check or draft that is not honored when presented for payment. This receipt is also void if there are any modifications made to the conditions of this receipt.

I have read, understand, and agree to all of the Terms and Conditions of this receipt and acknowledge receiving a copy of this receipt.

X

Signature of Proposed Insured

X

Signature of Proposed Owner (if other than Proposed Insured)

RECEIVED from _____
this _____ day of _____, in the
year of _____, by check, or Electronic Fund Transfer (EFT)
authorization, the amount of \$ _____ in connection
with the Application, which bears the same date as this receipt.

X

Signature of Insurance Producer

Leave this copy with the Proposed Insured

Application for Insurance Conditional Receipt

Ameritas Life Insurance Corp. ("Company") P.O. Box 81889, Lincoln, NE 68501 / 800-745-1112, Fax 402-467-7335

Notice to Producer and Applicant

Premium should not be accepted if the amount applied for is over \$1,000,000 or the proposed insured: (1) is age 75 or older; or (2) has been treated for heart disease, diabetes, stroke, or cancer, within the past 12 months; or (3) has been admitted to a medical facility within the past 90 days; or (4) is a foreign national.

Notice to Applicant

PLEASE READ THIS RECEIPT CAREFULLY.

Terms and Conditions

All of the terms and conditions of this receipt must be fulfilled for insurance to be in effect on the "coverage date," subject to the maximum amount limitations listed below, or no insurance will be in effect under this receipt. The "coverage date" is the date of this application or Part II of this application or medical examination or other tests required by published rules of the Company used when considering the benefits applied for, whichever date is latest.

1. Premium Payment

For Universal Life insurance, the premium payment taken with this application must be equal to or greater than the full initial premium. For any other life insurance, the premium taken with this application must be equal to the full first premium for the mode of premium and the applied for benefits. All premium checks must be made payable to the Company. Do not make checks payable to the insurance producer or present a blank check.

2. Insurability

As of the "coverage date," the Company's Underwriting Officer must find the proposed insured to be an acceptable risk at standard premium rates for the benefits applied for without an exclusion or restrictive endorsement.

3. Maximum Amount

Any liability of the Company under this and any other receipts may not exceed the lesser of: (a) the amount applied for in this application, or in the case of Universal Life insurance, the initial specified amount applied for; or (b) \$1,000,000 of insurance and \$100,000 of accidental death benefits.

4. Termination of Conditional Insurance

If insurance is provided under this receipt, it will terminate on the date the policy(ies) is/are delivered to the applicant or the date a premium refund is mailed to the payor and/or a notice is sent that the application(s) will no longer be considered on a pre-paid basis. If the applicant withdraws from consideration for coverage or refuses an offer of coverage or the application(s) is/are declined by the Company, all premiums paid in connection with the policy(ies) will be refunded and no coverage will have been provided under this receipt.

5. Limitations

- a) **The Company's Liability:** Except as limited by this receipt, the Company's liability is governed by the terms of the policy(ies) applied for.
- b) **Suicide:** If the proposed insured commits suicide while sane or insane, the Company's liability under this receipt will be limited to a refund of the premium payment submitted with the application.
- c) **Misrepresentation:** If there are any incorrect, untrue, incomplete, or omitted statement(s) of material fact in the application, any supplemental form(s), or medical questionnaire(s) that would become a part of the policy(ies), no benefit will be payable under this receipt, and this receipt will become null and void. No knowledge of any fact on the part of any producer, broker, licensed representative, medical examiner, telephone interviewer, or other person shall be considered knowledge of the Company unless such fact is stated in the application.
- d) **Other:** If any provision of this receipt is not enforceable under state law, all other terms and conditions shall continue in full force and effect.

No insurance is provided under this Conditional Receipt unless all terms and conditions of this receipt are met. This receipt is void if the payment is made by a check or draft that is not honored when presented for payment. This receipt is also void if there are any modifications made to the conditions of this receipt.

I have read, understand, and agree to all of the Terms and Conditions of this receipt and acknowledge receiving a copy of this receipt.

X

Signature of Proposed Insured

X

Signature of Proposed Owner (if other than Proposed Insured)

RECEIVED from _____
this _____ day of _____, in the
year of _____, by check, or Electronic Fund Transfer (EFT)
authorization, the amount of \$ _____ in connection
with the Application, which bears the same date as this receipt.

X

Signature of Insurance Producer

Return this copy to the Company

Electronic Signature and Delivery Disclosures

Ameritas Life Insurance Corp. ("Company") P.O. Box 81889, Lincoln, NE 68501 / 800-745-1112, Fax 402-467-7335

Ameritas Life Insurance Corp. offers you the ability to fill out, sign and receive electronic policy pages. This disclosure will help you decide whether or not you would like to continue with this electronic process. Please read this carefully.

1. You are not required to sign electronically. If you prefer to consent to use electronic transactions, simply check the Accept box below. To decline your consent to use electronic transactions, simply check the Decline box below. If you decline your consent, a paper copy of your application and other policy documents will be mailed or provided by your agent without charge to you for your written signature.

Accept Electronic Policy Delivery

Decline Electronic Policy Delivery

You have the right to revoke your consent to use electronic transactions or notify the Company of any updated information by contacting the Company at the address or phone number listed above. Your consent will be effective until you revoke it. If you withdraw your consent, it will not affect the legal standing of any signed documents you may have previously submitted.

2. In order to electronically sign and receive electronic policy pages using this web site, your hardware and software requirements for access to and retention of the electronic forms are the following, at a minimum:

| | |
|----------------------------|--|
| Browsers: | Internet Explorer 9.0+ (Windows PC), Chrome Current Version (Windows PC), Mozilla Firefox Current Version (Windows PC), Safari IOS7+(ipad & iphone), Safari (Mac OS), Chrome (Android phone), Microsoft Edge (Windows 10 PC) |
| Email: | Access to a valid secure email account as set forth below. If your email account changes it is important that you contact your agent so the Company has current and accurate information. |
| Screen Resolution: | 800 x 600 minimum |
| Enabled Security Settings: | <ul style="list-style-type: none">• Allow per session cookies• Users accessing the internet behind a Proxy Server must enable HTTP 1.1 settings via proxy connection |

3. If you accept electronic delivery, you will always have the option of printing a copy of your completed electronic policy pages using your own printer. You may request in writing from the Company, a copy of any electronically submitted document. That request, specifically identifying the document by form name and by date, should be mailed via first class mail with sufficient postage to Ameritas Life Insurance Corp., at P.O. Box 81889, Lincoln, NE 68501. The Company will not charge a fee for this service.

4. This disclosure covers all electronic policy pages arising out of an application for life or disability income insurance coverage through the Company.

5. By signing documents electronically in lieu of a paper-based signature, you acknowledge your understanding that electronic signatures are legally binding in the United States and in other countries. You further represent that you have read the documents to be submitted electronically and that they have been accurately filled out.

6. If you consent to the use of an electronic signature to sign and receive Company electronic policy pages at your valid email address, sign below. The receipt of your electronically signed policy pages by the Company will demonstrate that you can access the electronic forms provided to you.

- I had dialogue with the agent and I understand precisely the intentions of the electronic signature and I have, when applicable, visual confirmation of the actual electronic signing process.
- I understand there will be automatic encryption and storage of my signature.
- I understand that I will be given a 4 digit access code to access and electronically sign my documents via DocuSign.

Proposed Owner Email Address: _____

Date: _____
Month Day Year

X _____
Signature of Proposed Owner

X _____
Signature of Agent/Producer

Print or Type Name of Proposed Owner

Non-Variable Life Policy

Internal and External Replacement Form

Ameritas Life Insurance Corp. P.O. Box 81889, Lincoln, NE 68501 / 800-745-1112, Fax 402-467-7335

Name of Policyholder: _____ Social Security #: _____

Name of Joint Policyholder: _____ Social Security #: _____

Policy number to be surrendered: _____

1. For which type of policy is the policyholder applying? _____
2. Which type of policy is being replaced? _____
3. Are you the agent of record on the policy that is being replaced? Yes No

| | Existing | Proposed |
|-----------------------|-----------------|-----------------|
| Face Amount | _____ | _____ |
| Death Benefit | _____ | _____ |
| Annual Premium | _____ | _____ |
| Cash Value | _____ | _____ |
| Loan Indebtedness | _____ | _____ |
| Dividends | _____ | _____ |
| Dividend Accumulation | _____ | _____ |
| Surrender Charges | _____ | _____ |

4. Why is the existing coverage no longer appropriate? (Use the back of this form or attach an additional sheet if you need more space.)

Please attach any illustrations used to present this case.

Agents selling this product must have reasonable grounds for believing that the recommendation they are making is suitable for their client on the basis of the facts disclosed by the client about the client's investments, other insurance products, financial situation, and needs. The agent shall make reasonable efforts to obtain information concerning (1) the client's financial status, (2) the client's tax status, (3) the client's investment objectives and, (4) such other information used or considered to be reasonable by the agent in making recommendation to the client.

Owner Signature _____ Date _____

Joint Owner Signature _____ Date _____

Agent Signature _____ Agency # _____ Date _____

To be completed in duplicate at the time of application.
One copy is to be retained by the applicant, the other submitted with the application.

Notice Regarding Replacement

Ameritas Life Insurance Corp. P.O. Box 81889, Lincoln, NE 68501 / 800-745-1112, Fax 402-467-7335

Replacing your life insurance policy or annuity?

Are you thinking about buying a new life insurance policy or annuity and discontinuing or changing an existing one? If you are, your decision could be a good one - or a mistake. You will not know for sure unless you make a careful comparison of your existing benefits and the proposed benefits.

Make sure you understand the facts. You should ask for the advice of the company or agent that sold you your existing policy to give you information concerning any proposed replacement.

As a general rule, there are disadvantages to dropping your existing life insurance or annuities. Hear both sides before you decide. That way you can be sure you are making a decision that is in your best interest.

Idaho Law requires your existing company to be notified that you may be replacing their policy.

Policies which may be replaced

| Company Name | Policy Number | Name of Insured |
|--------------|---------------|-----------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Applicant's Signature _____ Date _____

Joint Applicant's Signature _____ Date _____

Agent's Signature _____ Date _____

New Business Transmittal / Fax Cover Sheet

1068

Life and Disability Insurance

Ameritas Life Insurance Corp. P.O. Box 81889, Lincoln, NE 68501 / 800-745-1112, Fax 402-467-7335

Agent/Representative Information

Client Information

| | | | |
|------------------|------------|------------------------|-----------------------------|
| Name | | Name | |
| Agency # | Agent # | Date of Birth | |
| State | | Social Security Number | |
| Telephone Number | Fax Number | Date | Number of pages being faxed |
| Agent E-mail | | | |

Product(s) being applied for: VUL WL Term UL Survivorship DI

Term _____

▲ Provide existing policy numbers for **SAME PAYOR DISCOUNT** if applicable

Is this a Combo Life & DI application? Yes No

Enclosures: (Check all items to be faxed or to follow)

| Attached | To Follow | | Attached | To Follow | |
|--------------------------|--------------------------|---|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Application | <input type="checkbox"/> | <input type="checkbox"/> | APS – Doctor/Facility |
| <input type="checkbox"/> | <input type="checkbox"/> | Check (Amount of check \$ _____) | <input type="checkbox"/> | <input type="checkbox"/> | EFT Form with voided check |
| <input type="checkbox"/> | <input type="checkbox"/> | Teleunderwriting / EZ App Order # _____ | <input type="checkbox"/> | <input type="checkbox"/> | Income Documentation |
| <input type="checkbox"/> | <input type="checkbox"/> | LabSlip | <input type="checkbox"/> | <input type="checkbox"/> | Replacement / 1035 Exchange (<i>mail original</i>) |
| <input type="checkbox"/> | <input type="checkbox"/> | Part II Med or Paramed | <input type="checkbox"/> | <input type="checkbox"/> | Illustration / UN 0008 |
| <input type="checkbox"/> | <input type="checkbox"/> | IR / PHI Order# _____ | <input type="checkbox"/> | <input type="checkbox"/> | Licensing Paperwork |

Comments: _____

DO NOT MAIL ORIGINAL APPLICATION

Please Note:

- One application per fax transmission. **Fax to 402-467-7335.**
- Before faxing a copy of the check, write the insured's SSN & full name in the memo portion of the initial premium check.
- Include a copy of this form when mailing the original check and replacement/transfer paperwork.
- **U.S. Mail to** Client Service Office, P.O. Box 81889, Lincoln, NE 68501.
- **Express Mail to** Client Service Office, 5900 O Street, Lincoln, NE 68510.

ATTACH CHECK HERE

Original check must be received in 10 days.

Ameritas Life Insurance Corp. ("Company") P.O. Box 81889, Lincoln, NE 68501 / 800-745-1112, Fax 402-467-7335

Typically a "policy illustration" is provided to help you understand, in general terms, how a policy will work. A policy illustration shows policy premiums, death benefits, cash values and information about other items that can affect the performance of your policy. Because a policy illustration for the specific policy you are applying for was not provided, we ask that both you and your agent acknowledge:

1. Either no policy illustration was used when recommendations were made by my agent or the illustration provided was different than the policy applied for, or
2. A computer screen illustration for the policy applied for was displayed but not printed, and
3. I understand an illustration reflecting the actual policy issued as a result of this application will be provided at the time of policy delivery.

Applicant (*print name*)

X

Applicant's Signature

Date

Agent (*print name*)

Agency No.

X

Agent's Signature

Date

Proposed Insured (*if different than applicant*) (*print name*)

Instructions to Agent

Submit signed and dated form with the application to the Client Service Office.

Electronic Fund Transfer (EFT)

Ameritas Life Insurance Corp. ("Company") P.O. Box 81889, Lincoln, NE 68501 / 800-745-1112, Fax 402-467-7335

Premium Mode Monthly EFT

Add to Existing EFT - provide Policy Number and Insured: _____

Withdrawal Date / (The withdrawal date must be on or before the policy date and cannot be after the 28th)
Month / Day

| Policy Number / Product Applied for | Print Name of Insured | Monthly Premium | Monthly Loan Payment | New Policies Only: Draft Initial Premium |
|-------------------------------------|-----------------------|-----------------|----------------------|--|
| | | \$ | \$ | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | \$ | \$ | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | \$ | \$ | <input type="checkbox"/> Yes <input type="checkbox"/> No |

new policies only: Initial Modal Premium* Draft will occur on the issue date of the policy.

| Policy Number / Product Applied for | Print Name of Insured | Initial Premium | Mode |
|-------------------------------------|-----------------------|-----------------|---|
| | | \$ | <input type="checkbox"/> Annual <input type="checkbox"/> Semi-annual <input type="checkbox"/> Quarterly |
| | | \$ | <input type="checkbox"/> Annual <input type="checkbox"/> Semi-annual <input type="checkbox"/> Quarterly |
| | | \$ | <input type="checkbox"/> Annual <input type="checkbox"/> Semi-annual <input type="checkbox"/> Quarterly |

***EFT not available for Initial Premium on Annuity products.** Review the receipt to verify if the Proposed Insured qualifies to submit premium with the application. Note: Signing the Electronic Fund Transfer form does not mean that insurance is effective. Insurance is effective only if requirements of the Application for Insurance Receipt are satisfied.

The Company indicated above, hereby requested and authorized, subject to its approval, to draw checks, drafts Checking Bank or orders monthly, whether by electronic or paper means, to be charged against the (check one in each column): Saving Credit Union

Bank Account Holder - print name and address as shown on Bank Records

Name of Bank and Branch Name, if any, and address where account is maintained

Transit/ABA Routing Number

Bank Account Number

- Refer to the check diagram at right to help determine your bank routing number and bank account number.**



**** For Variable Life contracts and Annuity contracts, a copy of a Pre-printed Voided Check is required. In some other circumstances we will require a copy of a pre-printed, voided check or a letter from the bank indicating the ABA Routing Number, Account Number, and the Account Holder's Name for verification.**

IT IS UNDERSTOOD THAT: Either or both of the above arrangements may be terminated by the Policy Owner or by the Company upon written notice. If the Bank Account Holder ("Payor") is other than the Policy Owner, the Company will terminate either or both of the arrangements upon written request of such Payor. Should the Premiums cease to be paid by Electronic Payment, the Company will accept payment of quarterly, semiannual or annual premium payments at the Company's published rates in effect as of the date of the policy.

For Policies Earning Dividends: Dividends cannot be used to offset Electronic Premium Payments. If dividends are currently being used to reduce premiums, please submit a dividend change form (UN 3379 B).

As a convenience to me (Payor and undersigned), I hereby request and authorize the Company, to pay and charge to my account checks, drafts or orders, whether by electronic or paper means, drawn on my account by the Company to its own order. This authorization will remain in effect until revoked by me in writing, and until the Company actually receives such notice I agree that the Company shall be fully protected in honoring any such order.

I (Payor and undersigned) understand that premium payments are necessary to fund the policy. If my financial institution does not honor a withdrawal, I may be required to send the Company a replacement payment. If the Company does not receive a replacement payment within the time required, the policy may enter its grace period and then lapse. Once a policy lapses, it no longer offers life insurance coverage.

The bank shall be under no obligation to furnish me (Payor and undersigned) with any special advice or notice in writing or otherwise of the payment and charge of such checks, drafts, or orders to my account.

Declaration: By signing this form I certify that I am an authorized signature for the bank account listed above.



Signature of Bank Account Holder

Date

Phone Number of Bank Account Holder