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. **For Life policies: 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** ☐ **Disability Income**

Application Checklist

			Included?	
Provide to Insured	UN 2550 NI	Notice of Insurance Practices	☐ Yes	N/A
Always Submit	UN 2550 PI-A	Personal Information	☐ Yes	N/A
Submit as Required	UN 2550 PI-B	Personal Information	☐ Yes	☐ No
	UN 2550 PD	Universal Life/Traditional Life Policy Details	☐ Yes	☐ No
	UN 2550 IUL	Supplemental Application for Index UL	☐ Yes	☐ No
	UN 2550 PDV	Variable Universal Life Policy Details	☐ Yes	☐ No
	UN 2550 IAV	Investment Advisory Agreement	☐ Yes	☐ No
	UN 2550 APEP	Excel Performance VUL Allocation of Premiums	☐ Yes	☐ No
	UN 2550 FI	Life Financial Information	☐ Yes	☐ No
	UN 2550 DI	Disability Income Policy Details	☐ Yes	☐ No
	UN 2550 DI FI	Disability Income Occupation and Financial Details	☐ Yes	☐ No
	UN 2550 LQ	Lifestyle Questionnaire	☐ Yes	☐ No
	UN 2550 HQ	Health Questionnaire (for each proposed insured)*	☐ Yes	☐ No
Always Submit	UN 2550 AG	Agreement	☐ Yes	N/A
	UN 2550 AU	Authorization	☐ Yes	N/A
	UN 2550 PS	Producer's Statement	☐ Yes	N/A
	UN 1891 TIA	Temporary Insurance Agreement**	☐ Yes	N/A
Always Submit	W-9***	TIN cert. (if WL Div. Option = Accum. At Int. or US entity policy owner) – See #5 and/or #6 above	☐ Yes	N/A
	W-8 BEN***	TIN cert. Foreign Status policy owner (individual – See #6 above)	☐ 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. If you learn of any adverse information after the application has been submitted and before the policy is issued or delivered, you are required to report it immediately.

** Temporary Insurance Agreement 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, or $8,000 per month of Disability Income or Disability Overhead Expense. 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, agents, 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 agent 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

Application for Insurance Personal Information

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

1. Proposed Insured (One):

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: _____

2. Owner Information (One):

(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 Individual Disability Income

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

Under the terms of the policy(ies) applied for below, no monthly benefit is payable during the elimination period of any disability.

1. Individual Disability Income Insurance:

a) Contract Type
- ☐ Noncancelable and Guaranteed Renewable *(4501NC)*
- ☐ Guaranteed Renewable *(4502GR)*

b) Definition of Disability
- ☐ Own Occ for benefit period *(OO)*
- ☐ Own Occ and Not Working for benefit period *(NW)*
- ☐ 60 month Own Occ and Not Working thereafter *(ON)*

c) Base Monthly Benefit: $_____

d) Elimination Period *(days)*:
☐ 30 ☐ 60 ☐ 90 ☐ 180 ☐ 365 ☐ 730

e) Benefit Period:
☐ 1 Year ☐ 2 Years ☐ 5 Years ☐ 10 Years
☐ To Age 65 ☐ To Age 67 ☐ To Age 70

f) Riders:
- ☐ Enhanced Residual Disability Rider
- ☐ Basic Residual Disability Rider
- ☐ Cost of Living Adjustment Rider – 6% Compound
- ☐ Cost of Living Adjustment Rider – 3% Simple
- ☐ Social Insurance Substitute Rider:
  Amount: $_____ Elimination Period *(days)*: _____
- ☐ Catastrophic Disability Rider:
  Amount: $_____ Elimination Period *(days)*: _____
  Benefit Period *(years)*: _____
- ☐ Student Loan Repayment Rider *(complete SLRR supp app)*
- ☐ Future Increase Option Rider: Amount $_____
- ☐ Automatic Increase Rider
- ☐ Other: _____

2. Business Overhead Expense (4503NCBOE):

a) Maximum Monthly Benefit: $_____

b) Elimination Period *(days)*: ☐ 30 ☐ 60 ☐ 90

c) Benefit Period *(months)*: ☐ 12 ☐ 18 ☐ 24

d) Riders:
- ☐ Extended Residual Disability Rider
- ☐ Future Increase Option Rider: Amount $_____
- ☐ Substitute Salary Expense Rider: Amount $_____
- ☐ Business Loan Repayment Rider *(complete BLRR supp app for each)*

	Rider #1	Rider #2	Rider #3
Amount (nearest $10):	$_____	$_____	$_____
Elimination Period *(days)*:	_____	_____	_____
Duration *(years)*:	_____	_____	_____

3. Payor:

a) Premium Payor:
☐ Insured ☐ Employer ☐ Other: _____

If employer is paying the Disability Income premium:

What percentage will be paid by employer? _____%

Is this amount included in your taxable income? . . . ☐ Yes ☐ No

b) Send Premium Notices to:
☐ Residence ☐ Business
☐ Other *(specify relationship and address)*

_____

_____

c) Premium Frequency:
☐ Annual ☐ Electronic Funds Transfer *(complete EFT form)*
☐ Semi-Annual ☐ Salary Allotment/List Bill
☐ Quarterly List bill number: _____
☐ Step Rate ☐ Other: _____

d) Has any premium been given in connection with this application? *(if "Yes," state amount paid and complete Temporary Insurance Agreement form)* . . . ☐ Yes ☐ No

Disability Income: $_____

Business Overhead: $_____

If this is a request for a **one-time** initial draft of the direct modal premium, check here ☐ and complete EFT form.

4. Business Ownership:

a) Do you have any ownership in the business where you work?
☐ Yes ☐ No If "Yes," what percent do you own? _____%

b) If yes, what type of business is it?
☐ C-Corp ☐ S-Corp ☐ LLP
☐ LLC ☐ Partnership ☐ Sole Proprietor
☐ Other: _____

c) If yes, how many other owners or partners are there? _____

5. Occupation / Employment:

a) How many total employees are there in the business where you work? _____

b) How long have you been employed at the business where you work? _____

c) How many hours per week do you work in your primary occupation? _____

d) How long have you worked in your primary occupation? _____

e) Do you have any other occupations not listed elsewhere on this application? . . . . . ☐ Yes ☐ No
(if "Yes," give details, including description of duties and hours worked per week)

_____

_____

f) Have you ever had a professional license suspended or revoked; or is such license under review; or have you been disbarred? *(if "Yes," give details)* . . . . . ☐ Yes ☐ No

_____

_____

Application for Insurance Financial and Occupation Information for Individual Disability Income

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

1. Financial Information:

a) Annual Earned Income for Federal income tax purposes: *(fill in each applicable section)*

	Current Tax Year *(Annualized)*	Last Tax Year	Two Tax Years Ago
Salary/ W-2 wages:	$	$	$
Sole Proprietor *(Schedule C)*:	$	$	$
Partnership *(Schedule E)*:	$	$	$
S-Corp *(Schedule E)*:	$	$	$
LLC or LLP *(Schedule E)*:	$	$	$
C-Corp *(Form 1120)*:	$	$	$

b) Annual Unearned Income for Federal income tax purposes, if greater than $20,000 *(rental income, interest, dividends, etc.)*: $

c) Do you receive a pension or profit sharing contribution from the business where you work? ☐ Yes ☐ No

d) If "Yes," what is the annual contribution? $

e) Have you ever filed for personal or business bankruptcy; or had any lawsuits, judgments, or liens against you? ☐ Yes ☐ No *(if "Yes," give details, including: dates, amounts, location, and status)*

f) Net Worth: *(if net worth exceeds $4,000,000, itemize below)*

Cash, savings, stocks, bonds: $

Personal residence: $

Other real estate: $

Business interest: $

Personal Property: $

Other *(describe)*: $

2. Insurance Details:

a) Do you have any group or individual disability insurance in force, or for which you will become eligible in the next year, or applications currently pending? ☐ Yes ☐ No

b) If "Yes," list coverage details in the following table. *(for type of coverage, indicate as: group, individual, association, overhead expense, key person, buy-out, etc.)*

	Policy 1	Policy 2
Company:		
Type of Coverage:		
Total Monthly Benefit:		
Issue Date:		
Paid to Date:		
Social Security Benefit:		
Automatic Increase Option:		
Future Increase Option:		
Employer Paid:		

3. Existing Insurance *(replacement):*

Will any disability insurance with us or any other insurance company be replaced, reduced or changed if the insurance now applied for is issued? ☐ Yes ☐ No *(if "Yes," give details)*

Company:

Policy Number:

Amount to be replaced: $

Other changes:

4. Insurance Producer's Replacement Statement:

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? ☐ Yes ☐ No *(if "Yes," give details)*

Company: Policy No.:

5. If applying for Business Overhead Expense Insurance, complete the following:

a) Not including you, what is the number of employees and partners in your profession in the business where you work?

Employees: Partners:

b) For what percent of the total monthly overhead expenses are you responsible? %

c) List that portion of monthly overhead expenses for which you are responsible: *(exclude: payments or salaries paid to you, partners or employees in your profession)*

Rent/Lease: $

Utilities: $

Telephone: $

Depreciation: $

Liability Insurance: $

Property Taxes: $

Salaries: $

Mortgage Interest: $

Payroll Taxes: $

Employee Benefits: $

Other: $

d) Salaries of partners or employees in your profession: $

e) If you are reimbursed in any manner for any of the above expenses, provide complete details:

Application for Insurance Lifestyle Questionnaire

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

Lifestyle Questions:

(please provide details for "Yes" answers)

Has any person proposed for coverage:

1. Used tobacco or nicotine products in any form within the last five years? *(in Details, provide dates and type: cigarettes, cigars, cigarillos, a pipe, chewing tobacco, nicotine patches, gum, etc.)* ☐ Yes ☐ No
2. 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. Ever received or claimed: indemnity, benefits, or a payment for any injury, sickness or impaired condition? ☐ Yes ☐ No
4. Ever made any flights as: a pilot, student pilot, or crew member of any aircraft? *(if "Yes," complete Aviation Questionnaire)* ☐ Yes ☐ No
5. Been convicted of a moving traffic violation, had any traffic accidents, or had a driver's license revoked or suspended within the past five years? ☐ Yes ☐ No
6. Been charged with, or convicted of, or currently awaiting trial on the violation of any criminal law? ☐ Yes ☐ No
7. In the next year, any intention of traveling outside the U.S. or Canada or residing outside of the U.S.? *(if "Yes," complete Foreign Travel Questionnaire)* ☐ Yes ☐ No
8. Belong to or intend joining: any active or reserve military, naval, or aeronautic organization? *(if "Yes," complete Military Service Questionnaire)* ☐ Yes ☐ No
9. Engaged in or plan to engage in any form of the following: *(if "Yes," check all boxes below that apply and complete appropriate form(s))* ☐ Yes ☐ No

   ☐ Motorized racing
   ☐ Parachuting/Skydiving
   ☐ Martial Arts
   ☐ Scuba diving
   ☐ Mountain climbing
   ☐ Other: _____

Proposed Insured One - Details for any "Yes" answers to Lifestyle Questions: *(indicate question number and timeframe)*

Proposed Insured Two - Details for any "Yes" answers to Lifestyle Questions: *(indicate question number and timeframe)*

Application for Insurance Health Questionnaire

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

Name of Proposed Insured: _____

Health Questions. Please complete Details for "Yes" answers.

1. a) Height: ___ ft. ___ in. b) Weight: _____ lbs.
   c) Has your weight changed by more than 10 lbs. 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 ten years, have you been medically evaluated for, diagnosed with or treated for:
   a) High blood pressure or high cholesterol levels? ☐ Yes ☐ No
   b) Disorder of the eyes, ears, nose or throat? ☐ Yes ☐ No
   c) Dizziness, vertigo, fainting, seizures, recurrent headache; speech defect, tremor, neuropathy, paralysis, multiple sclerosis, stroke, transient ischemic attack (TIA), memory loss, dementia or any other disorder of the brain or nervous system? ☐ Yes ☐ No
   d) Shortness of breath, chronic cough, bronchitis, asthma, emphysema, chronic obstructive pulmonary disease (COPD), sleep apnea, or chronic respiratory disorder? ☐ Yes ☐ No
   e) Chest pain, irregular heartbeat, heart murmur, heart valve disease, heart attack, coronary artery disease, heart failure, aneurysm or other disorder of the heart or blood vessels? ☐ Yes ☐ No
   f) Intestinal bleeding, inflammatory bowel disease (including Crohn's disease or ulcerative colitis), hepatitis, diverticulitis, recurrent indigestion or other disorder of the esophagus, stomach, intestines, pancreas, liver or gallbladder? ☐ Yes ☐ No
   g) Sugar, protein, or blood in urine; sexually transmitted disease (excluding HIV); chronic kidney disease, kidney stone or other disorder of the kidneys or bladder? ☐ Yes ☐ No
   h) Diabetes, elevated blood sugar, thyroid, pituitary, adrenal or other endocrine (glandular) disorders? ☐ Yes ☐ No
   i) Disorder of the breasts, reproductive organs, or prostate? ☐ Yes ☐ No
   j) C-section, miscarriage, or complication of pregnancy? ☐ Yes ☐ No
   k) Arthritis, gout, lupus or disorder of or injury to the bones, muscles, wrists, hips, knees or other joints? ☐ Yes ☐ No
   l) Spinal, neck or back disorder or injury, including sprains, strains, or disc disorder? ☐ Yes ☐ No
   m) Mass, polyp, cyst, tumor or cancer? ☐ Yes ☐ No
   n) Allergies; disorder of the skin; anemia, bleeding, clotting or other disorder of the blood? ☐ Yes ☐ No
   o) Anxiety, depression, stress, attention deficit hyperactivity disorder (ADHD), eating disorder or other psychiatric or mental health disorder? ☐ Yes ☐ No
   p) Chronic fatigue, chronic pain, fibromyalgia, or fever of unknown cause? ☐ Yes ☐ No
3. Are you currently pregnant? If yes, list expected due date. ☐ Yes ☐ No
4. Other than noted above, have you within the past five years:
   a) Consulted or received treatment from a chiropractor? ☐ Yes ☐ No
   b) Had a checkup, consultation for diagnosis or treatment, illness, injury, or surgery; been a patient in a hospital, rehabilitation center or other medical facility; had an X-ray, EKG, heart scan, MRI or CT scan, biopsy or other diagnostic test (excluding HIV)? ☐ Yes ☐ No
   c) Been advised by a licensed medical professional to have any diagnostic test (excluding HIV), hospitalization, or surgery which has not been completed? ☐ Yes ☐ No
5. Within the past ten 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) Sought, received or been advised to seek medical treatment, counseling or participation in a support group for the use of alcohol or drugs? ☐ Yes ☐ No
   c) Consumed alcoholic beverages? If yes, specify extent. ☐ Yes ☐ No
6. Have you been diagnosed by a licensed medical professional as having Acquired Immune Deficiency Syndrome (AIDS) or ever tested positive for Human Immunodeficiency Virus (HIV)? ☐ Yes ☐ No
7. Have you or your immediate family members (parents, brothers and sisters) died of or been diagnosed as having coronary artery disease, stroke, diabetes, cancer, polycystic kidney disease or Huntington's disease prior to age 60? ☐ Yes ☐ No
8. Family History

	Age if Living	Age at Death	Cause of Death
Father			
Mother			
Brothers			
Sisters			

9. 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 currently are 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 TEMPORARY INSURANCE AGREEMENT;

(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(s) and while his/her health and the facts and other conditions affecting their 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, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

Dated at: _____
City State Month Day Year

_____
Print or Type Proposed Insured Name

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

_____
Print or Type Other Proposed Insured Name
(or Personal Representative if insured is a minor)

X _____
Signature of Other Proposed Insured

_____
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 Licensed Soliciting Producer Producer State Lic. No.

_____
Print or Type Insurance Producer Name

_____ _____ _____
Producer No. Sit. Code % Split

X _____ _____
Signature of Licensed Soliciting Producer Producer State Lic. No.

_____ _____
Agency Name Agency No.

_____
Print or Type Insurance Producer Name

_____ _____ _____
Producer No. Sit. Code % Split

X _____ _____
Signature of Licensed Soliciting 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 Name *(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 and/or disability income 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

_____
Print or Type Other Proposed Insured Name

X _____
Signature of Proposed Insured

X _____
Signature of Other Proposed Insured

_____
Print or Type Name of Personal Representative of Proposed Insured

X _____
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)

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. Background Information

a) How well acquainted are you with the purchaser?

☐ First Contact ☐ Well Known
☐ Casually ☐ Self
☐ Relative *(relationship)*: _____

b) Initial contact with purchaser?

☐ Friend/Relative ☐ Direct-Mail Lead
☐ Referred Lead ☐ Home-Office Lead
☐ Cold Call
☐ Other: _____

c) Marital Status of the Insured:

☐ Single ☐ Married
☐ Divorced ☐ Widowed

2. Was this a Competitive Situation? ☐ Yes ☐ No

Competing Company: _____

3. Did you receive Home Office Assistance? ☐ Yes ☐ No

Name: _____

4. Life Insurance Information

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

b) If proposed insured is under 18 years of age:

Amount of insurance in force on life of parents: $ _____

Are all minor brothers and sisters insured for an equal amount? . . . . . ☐ Yes ☐ No

Purpose of Insurance:

c) Personal Life Insurance

☐ Survivor Needs ☐ Mortgage Acceleration
☐ Spouse Insurance ☐ Income Replacement
☐ Education Funding ☐ Retirement Funding
☐ Other *(specify)*: _____

d) Business

☐ Key Person ☐ Executive Bonus (Sec. 162)
☐ Business Purchase ☐ Split Dollar
☐ Cover Debt ☐ Dual Executive Reward (DER)
☐ Deferred Compensation
☐ Other *(specify)*: _____

e) Estate

☐ Charitable Gifts ☐ Fund Trusts for Heirs
☐ Estate Tax ☐ Equalization between Heirs
☐ Other *(specify)*: _____

Association Discount: ☐ Yes ☐ No *(if "Yes," provide IPN.)*

Association IPN: _____

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

If "Yes," give details: _____

(b) If yes, did you give advice to use Qualified funds? ☐ Yes ☐ No

6. Was the application signed in the owner's resident state? ☐ Yes ☐ No

If "No" please provide us with reason why:

_____

7. Request for Additional Life Policy(ies)

☐ Additional Policy *(if requested, provide details):*

_____

8. Underwriting Class Quoted

_____

☐ Tobacco ☐ Nontobacco

9. Disability Income Insurance Information

a) DI Occupational Class Quoted:

☐ 6A-P* ☐ 6A ☐ 5A ☐ 4A ☐ 3A ☐ 2A ☐ A ☐ B
☐ 6M-P* ☐ 6M ☐ 5M ☐ 4M ☐ 3M ☐ 2M ☐ M

*Preferred Occupation Premium

b) BOE Occupation Class Quoted:

☐ 6A ☐ 5A ☐ 4A ☐ 3A
☐ 6M ☐ 5M ☐ 4M ☐ 3M ☐ 2M

c) Discount (if applicable):

☐ Multi-life ☐ Association ☐ Big Case

IPN, if existing: _____

10. Producer Remarks

_____

_____

11. 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 Home Office.
- 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

_____
Print Full Name of Insurance Producer

Insurance Producer Number: _____

Agency Number: _____

Temporary Insurance Agreement

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

This Temporary Insurance Agreement (TIA) may provide LIMITED coverage, as described herein, while we review the Proposed Insured's application (Application) to determine if we will issue the policy(ies) applied for. This TIA does not commit the Company to issue any policy(ies).

Part 1: Questions

Complete Sections A and B if applying for Life Insurance, Sections B and C if applying for Disability Income or Business Overhead Expense Insurance (Disability Insurance), and all three Sections if applying for both Life and Disability Insurance.

NO REPRESENTATIVE OF THE COMPANY IS AUTHORIZED TO ACCEPT MONEY IN CONSIDERATION FOR:

- **LIFE INSURANCE, if any of the questions in Sections A and B below are answered "Yes" or left blank with respect to the Proposed Insured, as NO life Insurance coverage will take effect under this TIA as a result of a blank or "Yes" answer; and**
- **DISABILITY INSURANCE, if any of the questions in Sections B and C below are answered "Yes" or left blank with respect to the Proposed Insured, as NO disability insurance coverage will take effect under this TIA as a result of a blank or "Yes" answer.**

A. If applying for Life Insurance:

1. Is the Proposed Insured less than 15 days old or above age 70? ☐ Yes ☐ No
2. Does the total amount of insurance applied for exceed $3,000,000? ☐ Yes ☐ No
3. Is the policy applied for a Survivorship life insurance policy? ☐ Yes ☐ No

B. If applying for Life and/or Disability Insurance:

Has the Proposed Insured:

1. In the past five years:
   a. Received treatment for, been advised to seek treatment for, or been diagnosed by a licensed medical professional as having a stroke, cancer, tumor, chest pain or heart attack? ☐ Yes ☐ No
   b. Received treatment, attended a program or been counseled for alcohol or drug abuse, or been advised by a licensed medical professional to receive such treatment? ☐ Yes ☐ No
2. In the past 90 days:
   a. Had any surgery, or been advised to have surgery, or been admitted to a hospital or medical facility, or been advised or referred by a licensed medical professional for admission to a hospital or medical facility? ☐ Yes ☐ No
   b. Had any diagnostic test, excluding tests for the Human Immunodeficiency Virus (HIV), for which the results are unknown, or been advised by a licensed medical professional to have any diagnostic test, excluding tests for HIV, which has not yet been completed? ☐ Yes ☐ No

C. If applying for Disability Insurance, also answer the following:

1. Is the Proposed Insured above age 60? ☐ Yes ☐ No
2. In the past five years, has the proposed insured received treatment for, been advised to seek treatment for, or been diagnosed by a licensed medical professional as having any of the following: diabetes; an emotional or mental disorder; or any disease, disorder or problem of the kidneys, arteries, neck, or back? ☐ Yes ☐ No
3. Within the past 12 months, has the proposed insured applied for, been declined for, or had issued any other individual disability insurance? ☐ Yes ☐ No

Part 2: Limited Coverage

No matter how much insurance has been applied for or how much of an advanced payment has been made, this TIA provides limited coverage as described below. Additionally, this TIA does not provide or cover any additional benefits or riders that may have been applied for in the Application.

A. Life Insurance: If the Proposed Insured dies during the TIA coverage period, any liability of the Company may not exceed the lesser of: (a) the initial base amount applied for in the Application; or (b) **$1,000,000**.

B. Disability Insurance: If the Proposed Insured becomes disabled during the TIA coverage period, any liability of the Company under this and any other agreements for Disability Income or Business Overhead Expense Insurance, will be limited as follows:

The monthly benefit will be the lesser of: (a) the amount of base benefit applied for in the Application, or (b) the amount of base benefit that would have been offered subject to current Company underwriting guidelines, or (c) **$5,000**.

The maximum benefit period provided under this TIA will be the shorter of: (a) the benefit period applied for in the Application or (b) 24 months.

Benefits will begin to accrue on the later of the day after the elimination period applied for is met or the 91st day of continuous total disability.

Part 3: Coverage Period

Coverage begins when the Application and this TIA have been completed and signed, a premium has been properly accepted as limited by Part 1 of this TIA, and the terms and conditions of this TIA have been met.

Coverage ends automatically on the earliest of the following dates:

1. 75 days after the date of this TIA,
2. The date coverage starts under any policy resulting from the Application,
3. Ten (10) days after the Company has approved the Application as other than applied for,
4. Five (5) days after the Company mails a notice that the Application is either declined or withdrawn, or
5. The day the Company refunds your premium.

Part 4: Limitations

1. **The Company's Liability:** Except as limited by this TIA, the Company's liability is governed by the terms and conditions of the policy(ies) for which you would have qualified based on current Company occupational and financial underwriting guidelines.
2. **Contestability for Misrepresentation:** The Company may contest and void this TIA for incorrect, untrue, incomplete, or omitted statements or any other material misrepresentation in the answers to the questions above in Part 1 or in any statement in the Application.
3. **Suicide:** If a Proposed Insured dies by suicide while sane or insane or from an intentionally self-inflicted injury, the Company's liability under this TIA will be limited to a refund of the premium payment submitted with the Application.
4. **Survivorship:** No coverage is provided under this TIA and no premium can be accepted in consideration for Survivorship life insurance.
5. **Disability Insurance:** No coverage is provided under this TIA for: (a) accidental bodily injury that occurs or sickness that first manifests before coverage begins under this TIA, or (b) occupations considered uninsurable based on current Company underwriting guidelines.
6. **Coverage: No coverage is provided for anyone other than the Proposed Insured.**
7. **Other:** If any provision of this TIA is not enforceable under state law, all other terms and conditions shall continue in full force and effect.

Part 5: Premium Payment

Make all checks or other forms of payment payable to **Ameritas Life Insurance Corp.** The minimum premium required for coverage under this TIA is the amount equal to the one-month premium for the Policy(ies) applied for regardless of payment mode.

RECEIVED from _____ this _____ day of _____ , in the year of _____ ,

by check, or Electronic Fund Transfer (EFT) authorization, the amount of $_____ (Life Insurance) and/or

$_____ (Disability Insurance) in connection with the Application, which bears the same date as this TIA.

Part 6: Signatures

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

I have read, understand, and agree to all the terms and conditions of this TIA and acknowledge receiving a copy of this TIA.

➔ _____

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

➔ _____

Signature of Proposed Owner
(if other than Proposed Insured)

➔ _____

Signature of Producer

Temporary Insurance Agreement

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

This Temporary Insurance Agreement (TIA) may provide LIMITED coverage, as described herein, while we review the Proposed Insured's application (Application) to determine if we will issue the policy(ies) applied for. This TIA does not commit the Company to issue any policy(ies).

Part 1: Questions

Complete Sections A and B if applying for Life Insurance, Sections B and C if applying for Disability Income or Business Overhead Expense Insurance (Disability Insurance), and all three Sections if applying for both Life and Disability Insurance.

NO REPRESENTATIVE OF THE COMPANY IS AUTHORIZED TO ACCEPT MONEY IN CONSIDERATION FOR:

- **LIFE INSURANCE, if any of the questions in Sections A and B below are answered "Yes" or left blank with respect to the Proposed Insured, as NO life Insurance coverage will take effect under this TIA as a result of a blank or "Yes" answer; and**
- **DISABILITY INSURANCE, if any of the questions in Sections B and C below are answered "Yes" or left blank with respect to the Proposed Insured, as NO disability insurance coverage will take effect under this TIA as a result of a blank or "Yes" answer.**

A. If applying for Life Insurance:

1. Is the Proposed Insured less than 15 days old or above age 70? ☐ Yes ☐ No
2. Does the total amount of insurance applied for exceed $3,000,000? ☐ Yes ☐ No
3. Is the policy applied for a Survivorship life insurance policy? ☐ Yes ☐ No

B. If applying for Life and/or Disability Insurance:

Has the Proposed Insured:

1. In the past five years:
   a. Received treatment for, been advised to seek treatment for, or been diagnosed by a licensed medical professional as having a stroke, cancer, tumor, chest pain or heart attack? ☐ Yes ☐ No
   b. Received treatment, attended a program or been counseled for alcohol or drug abuse, or been advised by a licensed medical professional to receive such treatment? ☐ Yes ☐ No
2. In the past 90 days:
   a. Had any surgery, or been advised to have surgery, or been admitted to a hospital or medical facility, or been advised or referred by a licensed medical professional for admission to a hospital or medical facility? ☐ Yes ☐ No
   b. Had any diagnostic test, excluding tests for the Human Immunodeficiency Virus (HIV), for which the results are unknown, or been advised by a licensed medical professional to have any diagnostic test, excluding tests for HIV, which has not yet been completed? ☐ Yes ☐ No

C. If applying for Disability Insurance, also answer the following:

1. Is the Proposed Insured above age 60? ☐ Yes ☐ No
2. In the past five years, has the proposed insured received treatment for, been advised to seek treatment for, or been diagnosed by a licensed medical professional as having any of the following: diabetes; an emotional or mental disorder; or any disease, disorder or problem of the kidneys, arteries, neck, or back? ☐ Yes ☐ No
3. Within the past 12 months, has the proposed insured applied for, been declined for, or had issued any other individual disability insurance? ☐ Yes ☐ No

Part 2: Limited Coverage

No matter how much insurance has been applied for or how much of an advanced payment has been made, this TIA provides limited coverage as described below. Additionally, this TIA does not provide or cover any additional benefits or riders that may have been applied for in the Application.

A. Life Insurance: If the Proposed Insured dies during the TIA coverage period, any liability of the Company may not exceed the lesser of: (a) the initial base amount applied for in the Application; or (b) **$1,000,000**.

B. Disability Insurance: If the Proposed Insured becomes disabled during the TIA coverage period, any liability of the Company under this and any other agreements for Disability Income or Business Overhead Expense Insurance, will be limited as follows:

The monthly benefit will be the lesser of: (a) the amount of base benefit applied for in the Application, or (b) the amount of base benefit that would have been offered subject to current Company underwriting guidelines, or (c) **$5,000**.

The maximum benefit period provided under this TIA will be the shorter of: (a) the benefit period applied for in the Application or (b) 24 months.

Benefits will begin to accrue on the later of the day after the elimination period applied for is met or the 91st day of continuous total disability.

Part 3: Coverage Period

Coverage begins when the Application and this TIA have been completed and signed, a premium has been properly accepted as limited by Part 1 of this TIA, and the terms and conditions of this TIA have been met.

Coverage ends automatically on the earliest of the following dates:

1. 75 days after the date of this TIA,
2. The date coverage starts under any policy resulting from the Application,
3. Ten (10) days after the Company has approved the Application as other than applied for,
4. Five (5) days after the Company mails a notice that the Application is either declined or withdrawn, or
5. The day the Company refunds your premium.

Part 4: Limitations

1. **The Company's Liability:** Except as limited by this TIA, the Company's liability is governed by the terms and conditions of the policy(ies) for which you would have qualified based on current Company occupational and financial underwriting guidelines.
2. **Contestability for Misrepresentation:** The Company may contest and void this TIA for incorrect, untrue, incomplete, or omitted statements or any other material misrepresentation in the answers to the questions above in Part 1 or in any statement in the Application.
3. **Suicide:** If a Proposed Insured dies by suicide while sane or insane or from an intentionally self-inflicted injury, the Company's liability under this TIA will be limited to a refund of the premium payment submitted with the Application.
4. **Survivorship:** No coverage is provided under this TIA and no premium can be accepted in consideration for Survivorship life insurance.
5. **Disability Insurance:** No coverage is provided under this TIA for: (a) accidental bodily injury that occurs or sickness that first manifests before coverage begins under this TIA, or (b) occupations considered uninsurable based on current Company underwriting guidelines.
6. **Coverage: No coverage is provided for anyone other than the Proposed Insured.**
7. **Other:** If any provision of this TIA is not enforceable under state law, all other terms and conditions shall continue in full force and effect.

Part 5: Premium Payment

Make all checks or other forms of payment payable to **Ameritas Life Insurance Corp.** The minimum premium required for coverage under this TIA is the amount equal to the one-month premium for the Policy(ies) applied for regardless of payment mode.

RECEIVED from _____ this _____ day of _____ , in the year of _____ ,

by check, or Electronic Fund Transfer (EFT) authorization, the amount of $_____ (Life Insurance) and/or

$_____ (Disability Insurance) in connection with the Application, which bears the same date as this TIA.

Part 6: Signatures

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

I have read, understand, and agree to all the terms and conditions of this TIA and acknowledge receiving a copy of this TIA.

➔ _____

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

➔ _____

Signature of Proposed Owner
(if other than Proposed Insured)

➔ _____

Signature of Producer

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:	• 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

Why Sign a Second Authorization?

Value-Added Underwriting

Ameritas
fulfilling life.

You reviewed and signed an additional Authorization Form allowing our Company's underwriting department to release medical information and other non-public information to Risk Insurance and Reinsurance Solutions (RIRS) and Fidelity Security Life Insurance Company (FSL) for the purpose of determining if a conditional disability insurance offer can be made by RIRS, on behalf of the issuing company, FSL.

The purpose of this form is to ensure you are aware of this action and that you are under no compulsion to consider this potential offer. Every effort will be made to offer a policy with our company, and the above option will only be used if and when our company is declining to make a disability offer based on our underwriting standards.

If, upon RIRS review, they decide to make a conditional offer, they will provide to your agent the information and he or she will contact you to discuss your options.

If you have any questions, please ask your agent and he or she can provide you further information. If you do not desire for your underwriting information to be provided for this review by RIRS, please let your agent know.

Authorization to Release Nonpublic Personal Health Information To an Unrelated Insurer

Ameritas
fulfilling life

The purpose of this Authorization is to direct and authorize Ameritas Life Insurance Corp. and affiliates, including Ameritas Life Insurance Corp. of New York (collectively, "the Companies") to forward all of the nonpublic personal information that is, or has been collected on behalf of the undersigned in connection with an application for insurance with the Companies, to Fidelity Security Life Insurance Company (FSL), an unaffiliated insurer, or Presidential Life Insurance Company ("PL"), an unaffiliated insurer, or Risk Insurance and Reinsurance Solutions, Inc (RIRS), FSL's and PL's third party underwriter, in order for an insurance policy to be underwritten by FSL or PL, in the event that an insurance policy with the Companies is declined.

(1) Applicant Information (please type or print)

Last Name:	First Name:		M.I.:
Street Address:	City:	State:	ZIP.:
Date of Birth:	Social Security No.		

(2) IMPORTANT – Your signature below means that you understand and agree to the following:

- I understand that this Authorization is voluntary.
- I understand that the nonpublic personal information that will be disclosed pursuant to this authorization will contain all of the information that the Companies collect, or have collected about me in connection with my application to the Companies for insurance, without limitation, including personally identifiable information such as my name, address, telephone number(s), social security number and date of birth, in addition to medical records, hospital records, clinical records, psychiatric and psychological records, pharmaceutical records, and other records relating to any medical, psychological, psychiatric and/or therapeutic treatment that I may have received at any time. I am aware that the information I am authorizing to be disclosed may contain health information about me that is highly confidential including, but not limited to, testing or treatment related to alcohol or drug abuse; psychiatric or mental conditions; HIV or sexually transmitted disease; genetic disorders; and/or Sickle Cell anemia.
- I understand that the information to be disclosed is protected by law and that the same information may be re-disclosed by the recipient and may no longer be protected by the same law(s) that applied in the first instance.
- I understand that I may revoke this Authorization at any time during its effective period, except to the extent that action has been taken in reliance on this authorization, by requesting such in writing to: Ameritas, Attn. Privacy Office, P.O. Box 81889, Lincoln, NE 68510-1889.
- I understand that without this completed form with my signature, my request to release the information described above to a third party will not be honored.

(3) Expiration:

This Authorization is effective for the disclosure of the information identified above only once to FSL or PL or RIRS and will expire after the disclosure has been made by the Companies.

I, the undersigned, hereby authorize the Companies to disclose the nonpublic personal information about me identified in Paragraph (2) above, to FSL or PL or RIRS. I acknowledge and understand that the Companies are relying on this Authorization to release the information outlined above and I agree to hold harmless the Companies, their employees, officers, directors, and their successors and assigns against any claims, losses, cost or damages which may arise in connection with the release of this information.

Applicant Signature:	Date:

HIV Antibody Test

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

Information Form for Insurance Applicant

AIDS

Acquired Immunodeficiency Syndrome (AIDS) is a life-threatening disorder of the immune system, caused by a virus, HIV. The virus is transmitted by sexual contact with an infected person, from an infected mother to her newborn infant, or by exposure to infected blood (as in needle sharing during intravenous drug use). Persons at high risk of contracting AIDS include males who have had sexual contact with another male, intravenous drug users, hemophiliacs, and persons who have had sexual contacts with any of these persons. AIDS does not typically develop until a person has been infected with HIV for several years. A person may remain free of symptoms for years after becoming infected. An infected person has a significant chance of developing AIDS over the next 10 years.

The HIV Antibody Test

Before you consent to testing, please read the following important information:

1. **Purpose.** This test is being run to determine whether you may have been infected with HIV. If you are infected, your options for obtaining life and health insurance may be limited. This test is not a test for AIDS; AIDS can only be diagnosed by medical evaluation.
2. **Positive Test Results.** If you test positive, you should seek medical follow-up with your personal physician because you may be infected with HIV.
3. **Accuracy.** An HIV test will be considered positive only after confirmation by a laboratory procedure that the state health officer has determined to be highly accurate. Nonetheless, the HIV antibody test is not 100% accurate. Possible errors include:
   a. **False positives:** The test gives a positive result, even though you are not infected. This happens only rarely and is more common in persons who have not engaged in high risk behavior. Retesting should be done to help confirm the validity of a positive test.
   b. **False negatives:** The test gives a negative result, even though you are infected with HIV. This happens most commonly in recently infected persons; it takes at least 4-12 weeks for a positive test result to develop after a person is infected.
4. **Possible Adverse Effects of Test.** A positive test result may cause you significant anxiety. A positive test result may limit your ability to obtain life, health, or disability insurance coverage in the future. Although prohibited by law, discrimination in housing, employment, or public accommodations may result if your test results were to become known to others. A negative result may create a false sense of security.
5. **Disclosure of Results.** A positive test result will be disclosed to you or the physician or county health department that you designate.
6. **Confidentiality.** Like all medical information, HIV test results are confidential. An insurer, insurance agent, or insurance-support organization is required to maintain the confidentiality of HIV test results. Certain disclosures of your test results may occur, however, including those authorized by consent forms that you may have signed as part of your overall application. Your test results may be provided to affiliates, reinsurers, employees and contractors of the insurer in relation to the underwriting of the insurance application. In addition, a positive result from a blood, oral specimen or urine test may be reported to MIB, Inc. ("MIB"), a national insurance data bank, as a nonspecific abnormality determined by the testing of blood, oral specimen, or urine.
7. **Prevention.** Persons who have a history of high risk behavior should change these behaviors to prevent getting or giving AIDS, regardless of whether they are tested. Specific important changes in behavior include safe sex practices (including condom use for sexual contact with someone other than a long-term monogamous partner) and not sharing needles.
8. **Information.** Further information about HIV testing and AIDS can be obtained by calling the Oregon AIDS hotline within the Portland area at 223-AIDS and outside the Portland area at 1-800-777-AIDS. Health insurance may be available through the Oregon Medical Insurance Pool for persons who are not otherwise able to obtain coverage. The telephone number for the Oregon Medical Insurance Pool is 800-542-3104 or 1-503-373-1692.

Informed Consent

I hereby authorize the insurance company named above (the Insurer) and its designated medical facilities to collect samples of my body fluids for the purpose of laboratory testing to provide applicable medical information concerning my insurability. These tests may include but are not limited to: tests for cholesterol and related blood lipids; diabetes; liver or kidney disorders; infection by the Acquired Immune Deficiency Syndrome (HIV) virus (if permitted by law); immune disorders; or the presence of medications, drugs, nicotine or their metabolites. The tests will be done by a medically accepted procedure which is extremely reliable.

If an HIV Antibody Screen is performed, it will be performed according to the following medical protocol: an initial ELISA test; if the initial ELISA test is positive, it is repeated; if it is negative, a negative finding is reported by the laboratory to the Insurer. If the second ELISA test is positive, a Western Blot test is used to confirm the previous positive results. If the second ELISA test is negative, a third ELISA test is performed. If the third ELISA test is positive, a Western Blot test is used to confirm the previous positive tests. If the third ELISA test is negative, a negative result is reported to the Insurer. Only if at least two ELISA tests and a Western Blot test are positive, will the result be reported as positive. All other results will be reported as negative.

If the report is positive, I choose to have the results delivered as follows:

☐ Personal Physician: (Name of Physician) _____

(Address) _____

(City, State, ZIP Code)_____

☐ County Health Department of _____ County, Oregon.

☐ Directly to the proposed insured.

Without a court order or a written authorization from me, these results will be made known only to the Insurer and/or its reinsurers (if involved in the underwriting process). The Insurer will provide results of all tests to a physician of my choice. In addition, the Insurer may make a brief report to MIB in the manner described in the prenotice which I received as part of the application process.

These organizations will be the only ones maintaining this information in any type of file except as required by law.

I acknowledge receipt of a copy of the Informational Brochure on HIV Antibody Tests.

I agree this authorization is valid for six months from the date shown below.

Dated at _____ , Month _____ , Day _____ , Year _____ .

Witness _____ Proposed Insured _____
(Agent)

New Business Transmittal / Fax Cover Sheet

1068

Life and Disability Insurance

RESET FORM

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

Agent/Representative Information

Name	
Agency #	Agent #
State	
Telephone Number	Fax Number
Agent E-mail	

Client Information

Name	
Date of Birth	
Social Security Number	
Date	Number of pages being faxed

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	
☐	☐	Application	☐	☐	APS – Doctor/Facility
☐	☐	Check (Amount of check $_____)	☐	☐	EFT Form with voided check
☐	☐	**Teleunderwriting / EZ App Order #** _____	☐	☐	Income Documentation
☐	☐	LabSlip	☐	☐	Replacement / 1035 Exchange ***(mail original)***
☐	☐	Part II Med or Paramed	☐	☐	**Illustration / UN 0008**
☐	☐	IR / PHI Order# _____	☐	☐	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.

Electronic Fund Transfer (EFT) • For use with UN 2550 or AS 2550 applications

RESET FORM 1150

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)

Policy Number / Product Applied for	Print Name of Insured	Monthly Premium	Draft Initial Premium
		$	☐ Yes ☐ No
		$	☐ Yes ☐ No
		$	☐ Yes ☐ No

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
		$	☐ Annual ☐ Semi-annual ☐ Quarterly
		$	☐ Annual ☐ Semi-annual ☐ Quarterly
		$	☐ Annual ☐ Semi-annual ☐ Quarterly

CHECK ONE

☐ Yes, with temporary coverage. I have applied for temporary coverage via the attached Temporary Insurance Agreement form. Premium will be drafted only after my application has been approved and the policy has been issued.

☐ Yes, without temporary coverage. Premium will be drafted only after my application has been approved and the policy has been issued. I understand that no temporary coverage will be in force during the underwriting process.

☐ No, I would like ongoing monthly premium drafts, but have included a check (payable to Ameritas Life) for the initial monthly premium.

*Review the Temporary Insurance Agreement 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 Temporary Insurance Agreement are satisfied.

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

Transit/ABA Routing Number (9 digits) — Bank Account Number

** **For Variable Life 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