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

			Included?	
Provide to Insured	UN 92 NI	Notice of Insurance Practices	☐ Yes	N/A
Always Submit	UN 92 PI	Personal Information	☐ Yes	N/A
Submit as Required	UN 92 PD	Universal Life/Traditional Life Policy Details	☐ Yes	☐ No
	UN 92 IUL	Supplemental Application for Index UL	☐ Yes	☐ No
	UN 92 PDV	Variable Universal Life Policy Details	☐ Yes	☐ No
	UN 92 IAV	Investment Advisory Agreement	☐ Yes	☐ No
	UN 92 APEP	Excel Performance VUL Allocation of Premiums	☐ Yes	☐ No
	UN 92 FI LHQ	Financial Information and Lifestyle and Health* Questionnaire	☐ Yes	☐ No
Always Submit	UN 92 AG	Agreement	☐ Yes	N/A
	UN 92 AU	Authorization	☐ Yes	N/A
	UN 92 PS	Producer's Statement	☐ Yes	N/A
	UN 92 CR	Conditional Receipt**	☐ 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	☐ 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.

** 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

Application for Insurance Personal Information

1010

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

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:

☐ Accidental Death Benefit Rider . . . $_____
☐ Accounting Benefit Rider . . . . . $_____
☐ Guaranteed Insurability Rider . . . . $_____
☐ Scheduled Increase Rider . . . . . _____%
☐ Supplemental Coverage Rider . . . . $_____
☐ Total Disability Benefit Rider . . . . $_____
☐ Waiver of Monthly Deduction Rider
☐ 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:

☐ Accidental Death Benefit Rider . . . $_____
☐ Flexible Paid-Up Rider:
☐ Single Premium . . . . . $_____
☐ Scheduled Premium . . . . . $_____
Premium Frequency: ☐ Annual ☐ Semi-Annual
☐ Quarterly ☐ Electronic Fund Transfer *(complete EFT form)*
☐ Salary Allotment ☐ Other: _____
☐ Guaranteed Insurability Rider . . . . $_____
☐ Level Term Rider . . . . . $_____
☐ 10 yr ☐ 15 yr ☐ 20 yr ☐ 30 yr
☐ One-Year Term Rider . . . . . $_____
☐ Term Paid-Up Rider (TPL) . . . . . $_____
☐ Total Disability Benefit Rider . . . . $_____
☐ Waiver of Premium Rider
☐ 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? *(in Details, provide date and company name)* ☐ Yes ☐ No
3. Made any flights as: a pilot, student pilot, or crew member of any aircraft in the past three years? *(if "Yes," complete Aviation Amendment)* . . . . . ☐ Yes ☐ No
4. Have you engaged in or plan to engage in the next 12 months in any form of: motorized racing, scuba diving, parachuting/skydiving, martial arts, mountain climbing? *(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 five years, have you been diagnosed with or sought medical treatment by a licensed medical professional 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 controlled substance, except as legally prescribed by a physician? . . . . . ☐ Yes ☐ No
   b) Consumed alcoholic beverages in the past year? . . ☐ Yes ☐ No
   If yes, specify extent: _____
4. Have you been diagnosed by a licensed medical professional as having Acquired Immune Deficiency Syndrome (AIDS)? ☐ 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, to the best of their knowledge or belief, as described in this application and Part II, if required; and

(2) the policy is delivered to the Owner;

(d) the policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the Company and, unless such approval be endorsed or attached to the policy, and no agent has authority to change this policy or to waive any of its provisions; 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

For your protection California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

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, treatment, use of drugs, alcohol or tobacco, AIDS or other related conditions, prescription drug records, financial status, education records, or employment status 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 two and one-half years from the date shown below. 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

X _____
Signature of 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)

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 "Opt-in" box below. If you do not choose to opt-in, 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.

   ☐ **Opt-in** 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 Opt-in 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 the following electronic policy pages arising out of an application for life or disability income insurance coverage through the Company: policies, schedule pages, riders, endorsements, applications, amendments, and exam where applicable.

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

Disclosure Notice for California Applicants Age 65 and Older

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

The sale or liquidation of any stock, bond, IRA, certificate of deposit, mutual fund, annuity or other asset to fund the purchase of this product may have tax consequences, early withdrawal penalties, or other costs or penalties as a result of the sale or liquidation. You and/or your agent may wish to consult independent legal or financial advice before selling or liquidating any assets and prior to the purchase of this product.

I acknowledge that I have read this Disclosure Notice.

Print or Type Applicant Name

X
Signature of Applicant / Trustee 1 / Officer 1

Print or Type Joint Applicant Name

X
Signature of Joint Applicant / Trustee 2 / Officer 2

X
Signature of Agent/Representative

Date

Notice Regarding Standards for Medi-Cal Eligibility and Recovery

For Distribution by Insurers, Agents, and Brokers

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

IF YOU OR YOUR SPOUSE ARE CONSIDERING PURCHASING A FINANCIAL PRODUCT BASED ON ITS TREATMENT UNDER THE MEDI-CAL PROGRAM, READ THIS IMPORTANT MESSAGE!

You or your spouse do not have to use up all of your savings before applying for Medi-Cal.

Recovery

An annuity purchased on or after September 1, 2004, shall be subject to recovery by the state upon the annuitant's death under the regulations of the Medi-Cal Recovery Program. Income derived from the annuity must be used to meet the annuitant's share of costs and, if the annuitant is married, the income derived from the annuity may impact the minimum monthly maintenance needs of the annuitant's community spouse. An annuity purchased by a community spouse on or after September 1, 2004, may also be subject to recovery if that spouse is the recipient of past or future Medi-Cal benefits.

Unmarried Resident

An unmarried resident may be eligible for Medi-Cal benefits if he/she has less than $2,000 in countable resources.

The Medi-Cal recipient is allowed to keep from his/her monthly income a personal allowance of $35 plus the amount of any health insurance premiums paid. The remainder of the monthly income is paid to the nursing facility as a monthly share-of-cost.

Married Resident

COMMUNITY SPOUSE RESOURCE ALLOWANCE: If one spouse lives in a nursing facility and the other spouse does not live in a facility, the Medi-Cal program will pay some or all of the nursing facility costs as long as the couple together does not have more than $120,900 in countable resources.

MINIMUM MONTHLY MAINTENANCE NEEDS ALLOWANCE: If a spouse is eligible for Medi-Cal payment of nursing facility costs, the spouse living at home is allowed to keep a monthly income of at least his/her individual monthly income, or $3,023 in monthly income, whichever is greater.

Fair Hearings and Court Orders

Under certain circumstances, an at-home spouse can obtain an order from an administrative law judge or court that will allow the at-home spouse to retain additional resources or income. The order may allow the couple to retain more than $120,900 in countable resources. The order also may allow the at-home spouse to retain more than $3,023 in monthly income.

Real and Personal Property Exemptions

Many of your assets may already be exempt. Exempt means that the assets are not counted when determining eligibility for Medi-Cal.

Real Property Exemptions

- **One principal residence:** One property used as a home is exempt. The home will remain exempt in determining eligibility if the applicant intends to return home someday.

  The home also continues to be exempt if the applicant's spouse or dependent relative continues to live in it.

  Money received from the sale of a home can be exempt for up to six months if the money is going to be used for the purchase of another home.
- **Real property used in a business or trade:** Real estate used in a trade or business is exempt regardless of its equity value and whether it produces income.

Personal Property and Other Exempt Assets

- **IRAs, KEOGHs, and other work-related pension plans:** These funds are exempt if the family member whose name it is in does not want Medi-Cal. If held in the name of a person who wants Medi-Cal, and payments of principal and interest are being received, the balance is considered unavailable and is not counted. It is not necessary to annuitize, convert to an annuity, or otherwise change the form of the assets in order for them to be unavailable.
- Personal property used in a trade or business.
- One motor vehicle.
- Irrevocable burial trusts or irrevocable prepaid burial contracts.

There may be other assets that may be exempt.

This is only a brief description of the Medi-Cal eligibility rules. For more detailed information, you should call your county welfare department. Also, you are advised to contact a legal services program for seniors or an attorney that is not connected with the sale of this product.

Please note: If you seek Medi-Cal payment for nursing facility services, you may be ineligible for those services if payments from your annuity extend beyond your life expectancy based upon life expectancy tables adopted by the Department of Health Care Services for this purpose. To find out about these tables, you may contact your local county welfare department.

Finally, the Department of Health Care Services is currently refining its policy regarding the treatment of annuities when determining eligibility for nursing facility services. Any regulatory changes will only impact annuities that are purchased after the effective date of any regulatory amendments.

Different rules apply to annuities that are qualified retirement arrangements established pursuant to Title 26, Internal Revenue Code, Subtitle A, Chapter 1, Subchapter D, Part 1. In some circumstances, Medi-Cal does not count funds held in an IRA, Keogh, or other work-related retirement arrangement.

To find out if Medi-Cal would count your IRA, Keogh, or work-related retirement arrangements, you may contact your local county welfare department.

I have read the above notice and have received a copy.

Print or Type Applicant Name

X Signature of Applicant / Trustee 1 / Officer 1

Print or Type Joint Applicant Name

X Signature of Joint Applicant / Trustee 2 / Officer 2

Print or Type Applicant's Spouse Name

X Signature of Applicant's Spouse

Date

☐ Medi-Cal or any similar program was not discussed

X Signature of Agent/Representative

Non-Variable Life Policy

1041

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 the company or agent that sold you your existing policy to give you information about it.

Hear both sides before you decide. This way you can be sure you are making a decision that is in your best interest.

We are required by law to notify your existing company that you may be replacing their policy.

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

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.

Policy Illustration Certification

1045

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.

Special Notice for Policyowners

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

As policyowner, you have the right to name a third party designee who will receive duplicate copies of premium notices, reminder notices and any cancellation or lapse notices pertaining to this policy. Should you desire to terminate the third party designee at any time, you must provide written notice to the insurance company.

The third party designee must agree to this designation.

If this notice is not returned, then a third party designee has not been elected. Please be advised that we will be notifying you annually of this right.

☐ Yes, I (the policyowner) wish to designate a third party designee and understand that this individual will receive duplicate copies of premium notices, reminder notices and any cancellation or lapse notices pertaining to the policy listed below.

Policy Number: _____

Name of Third Party Designee (please print): _____

Street Address of Third Party Designee: _____

City: _____ State: _____ ZIP: _____

Phone Number: _____ Email Address: _____

Gender of Third Party Designee: ☐ Male ☐ Female Date of Birth of Third Party Designee: _____

Date: _____
Month Day Year

X _____ _____
Signature of Owner Type or Print Name of Owner

Note: Remove any prior named Third Party Designee

☐ Yes (default if nothing marked) Third Party Designee: _____

☐ No

☐ I agree to be named the third party designee of the policy listed above. I understand I will receive duplicate copies of premium notices, reminder notices and any cancellation or lapse notices. If in the future I no longer wish to be the third party designee, I will provide written notice to the policyowner and the insurance company.

Date: _____
Month Day Year

X _____ _____
Signature of Third Party Designee Print or Type Name of Third Party Designee

If you have any questions, please contact the Client Service Office at the number listed above.

Disclosure:

For the States of CT, NJ, RI

In accordance with the law, agreeing to be a third party designee does not constitute acceptance of any liability on the part of the third party designee for services provided to the policyowner nor on the part of the insurance company.

Electronic Fund Transfer (EFT)

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)
Month / Day

Policy Number / Product Applied for	Print Name of Insured	Monthly Premium	Monthly Loan Payment	New Policies Only: Draft Initial Premium
		$	$	☐ Yes ☐ No
		$	$	☐ Yes ☐ No
		$	$	☐ Yes ☐ 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
		$	☐ Annual ☐ Semi-annual ☐ Quarterly
		$	☐ Annual ☐ Semi-annual ☐ Quarterly
		$	☐ Annual ☐ Semi-annual ☐ 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 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.**

****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