# Application for Benefit Increase – Disability Income 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**

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RESET FORM

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

1. Name of Proposed Insured — First — Middle — Last

2. Social Security Number | 3. Birth Date | 4. Policy Number | 5. IPN *(if applicable)*

6. Residence Street Address — City — State — ZIP

7. Present Employer | 8. Base benefit increase | 9. SSE increase *(if applicable)*

10. Business Street Address — City — State — ZIP

11. Occupation and duties | 12. Hours/Week

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

| | | | |
|---|---|---|---|
| 14. Salary/W-2 Wages | $ | Pension and Profit-Sharing Contributions | $ |
| Commissions/ Bonuses | $ | Unearned Income *(if greater than $20,000)* | $ |
| Net Business Profit, if business owner | $ | Net Worth *(if exceeds $4,000,000)* | $ |

15. If applying for Business Overhead Expense, list the amount of overhead expenses for which you are responsible: $ _____

16. Has any premium been given in connection with this application? ☐ Yes ☐ No

17. List all Disability Insurance you have in force or applied for:

| Company | Coverage (DI, BOE, Other) | Type | Monthly Benefit | Employer Paid? |
|---|---|---|---|---|
| | | ☐ Ind. ☐ Group | | ☐ Yes ☐ No |
| | | ☐ Ind. ☐ Group | | ☐ Yes ☐ No |

18. Will any insurance with this or any other company be replaced, discontinued, reduced or changed if the insurance now applied for is issued? ☐ Yes ☐ No

If "Yes," give name of company: _____ and policy number: _____

19. Please include any additional details of answers to questions 1-18 *(attach additional sheet of paper, if needed).*

## Agreement

The undersigned agrees that the statements in this application are true and complete to the best of his/her knowledge and belief. It is agreed that only statements which are to be considered as the basis for the increase in benefits are those contained in: (1) this application; or (2) any amendment to this application.

Any increase in benefits issued as a result of this application will apply to a period of disability that starts after the effective date of the increase.

**Fraud Notice:** The falsity of any statement in this application shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer.

Dated at: _____ (City) _____ (State) Month: _____ Day: _____ , Year: _____

**X** _____
Signature of Proposed Insured *(always required)*

**X** _____
Signature of Policyowner *(if other than insured)*

**Producer:** _____
Print/Type Name

**X** _____
Signature

Producer Number / SIT Code

Agency Number

**Additional Producer Name / Number / SIT Code:** _____

# Application for Benefit Increase – Disability Income Insurance

1010

## 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

I authorize any health care providers, pharmacy benefit manager, hospitals, insurers, MIB, Inc. ("MIB"), consumer reporting agency, government agency, financial institution, or employer; having data or facts about the proposed insured's or claimant's physical or mental condition, medical care, treatment, the use of drugs, alcohol, or tobacco, AIDS or other related conditions, prescription drug records, financial status 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 the Company, or its reinsurers, to disclose data or facts obtained, including Protected Health Information, to the MIB. Data or facts obtained will be released only: (1) to reinsurers; (2) to the MIB; (3) to persons performing business duties as directed or contracted for by the Company related to the proposed insured's application or claim or other insurance-related functions; (4) as permitted or required by law; (5) to government officials when necessary to prevent or prosecute fraud or other illegal acts; and (6) to any person or entity having an authorization expressly permitting the disclosure. I acknowledge and agree that the personal data or facts used or disclosed under this authorization may be subject to redisclosure and no longer protected by federal privacy regulations.

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 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.

Dated at: _____ Month: _____ Day: _____ , Year: _____
City State

_____ **X** _____
Print or Type Proposed Insured Name Signature of Proposed Insured

This Authorization complies with the HIPAA Privacy Rules.