Application for Insurance Instructions

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

1. If either of the following special programs apply, check the appropriate box below:
   - ☐ EZ App (teleunderwriting) program – See **UN 1263** for EZ App order instructions
   - ☐ Jet Issue program (life insurance only) – See **UN 1263 JI** for Jet Issue order instructions

2. For EZ App or Jet Issue program applications, the agent/agency orders the teleunderwriting package. You are not responsible for ordering a paramedical exam since that is part of the EZ App/Jet Issue order package. Twenty-four hours after the order is placed by the agent/agency, your client can call to have the phone interview completed by calling ExamOne at 800-242-9266 during the hours of:
   - Monday – Thursday, 7 a.m. – 11 p.m. CST
   - Friday, 7 a.m. – 9 p.m. CST
   - Saturday, 8 a.m. – 4 p.m. CST

   Upon completion of this call, necessary medical requirements will automatically be ordered and completed by ExamOne.

3. Because the health questionnaire is not submitted with the application, providing the information below will assist in expediting the process by enabling the underwriter to order potentially necessary medical records earlier in the process. It also provides you, as the producer, with enough insight into the proposed insured's medical history that you may better prepare your client for the likely underwriting decision.

   Current height: ____________ weight: ____________

   In the last five years, has the proposed insured been medically evaluated for, diagnosed with or treated for any of the following:
   - ☐ Heart condition, chest pain or stroke
   - ☐ Diabetes
   - ☐ Anxiety, depression, attention deficit hyperactivity (ADHD) or any other psychiatric or mental health disorder
   - ☐ Cancer
   - ☐ Alcohol or drug abuse or dependency
   - ☐ Spine, neck or back disorder

   If yes, please provide details below, including condition, date of diagnosis, treatment, and name/address of physician treating the condition:

   ____

   ____

   ____

   ____

   ____

4. The Notice of Insurance Information Practices must be given to the client prior to completion of the application.

5. If premium payment or Electronic Fund Transfer (EFT) authorization is obtained with the application, follow all instructions as indicated in the Temporary Insurance Agreement portion of the application kit.

6. Make sure that all necessary signatures are provided on the application form where indicated.

7. We cannot accept life insurance applications for minors younger than fifteen (15) days old.

8. 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.

9. When a life or disability income contract is being replaced, adhere to replacement procedures.

10. If, after the time of application, you learn any information that affects the client's insurability, you are required to report it immediately up to and including the point of delivery.

11. Whole Life contracts: if dividend option Accumulate with Interest is selected, an IRS Form W-9 must be returned to the client service office.

12. **For life policies: The Foreign Account Tax Compliance Act (FATCA) requires: (a) IRS Form W-9 for all U.S. 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.** ***

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

what you can expect

EZ APP Teleunderwriting

You have chosen important insurance coverage. The next step in the application process is a telephone interview so that you may provide your medical and lifestyle information in the comfort of your home or office. Our professional interviewer will contact you in the next 24-48 hours. This interview should take about 20-30 minutes to complete.

Telephone Interview

During the interview, you will be asked basic questions about yourself such as:

- Medical and prescription history
- Tobacco use
- Hobbies, travel and sports

This section has been provided as a convenient place to record your information. Please have the information below available at the time of the interview to expedite the process.

Names, addresses and phone numbers of physicians and medical facilities that have provided you with medical care:

____

____

Diagnosis and dates of any significant medical conditions:

____

____

Prescribed medications, including dosage and frequency:

____

____

Driver's license number and state of issue:

____

____

Mini-Examination

A mini-examination (mini-exam) may be required to complete the application process. The telephone interviewer will schedule a visit (if necessary) from a qualified medical professional to collect height, weight, blood pressure, pulse, a blood and urine sample, and, in some instances, an electrocardiogram (EKG). This mini-exam may be performed at your convenience in the privacy of your home, office, or an independent medical facility, if one is available in your area. Please have your calendar available to help identify the most convenient date and time for your mini-exam. If you have any questions, please contact your insurance representative. If a mini-exam is required, use this space to write down the time and date of the mini-exam:

____

____

Mini-Exam Tips: Please follow these suggestions prior to your exam.

- Abstain from eating or drinking (except water) for 12 hours prior to your mini-exam, if your health permits.
- Do not drink alcoholic beverages for 12 hours prior to your mini-exam.
- Do not smoke or chew tobacco for at least one hour prior to your mini-exam.
- Do not engage in strenuous physical activity 12 hours prior to your mini-exam.

This information is provided by Ameritas Life Insurance Corp. For more information about Ameritas®, visit ameritas.com.

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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 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 Occupation for benefit period *(OO)*
- ☐ Own Occupation and Not Working for benefit period *(NW)**
- ☐ 60 month Own Occupation and Not Working thereafter *(ON)**
- ☐ Any Occupation and Not Working for benefit period*

*If you choose to work at any job, you will not be considered totally disabled but you may qualify for partial or residual disability benefits.

c) Base Monthly Benefit: $ ____________________

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

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

f) Partial Disability Benefit (must choose one, if Occupation other than A, B, or M):
- ☐ Basic
- ☐ Enhanced

g) Optional Riders:
- ☐ Cost of Living Adjustment Rider – 6% Compound
- ☐ Cost of Living Adjustment Rider – 3% Simple
- ☐ Social Insurance Substitute Rider:

  Amount: $__________ Elimination Period *(days)*: ______
- ☐ 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 Partial Disability Rider
- ☐ Future Increase Option Rider: Amount $ __________
- ☐ Substitute Salary Expense Rider: Amount $ __________
- ☐ Business Loan Repayment Rider *(complete BLRR Supp. App.)*

  Monthly benefit: $__________ *(round up to nearest $10)*

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

  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
- ☐ Semi-Annual
- ☐ Quarterly
- ☐ Step Rate
- ☐ Electronic Funds Transfer *(complete EFT form)*
- ☐ Salary Allotment/List Bill

  List bill number ____________
- ☐ 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?
☐ 10 or less ☐ 11-25 ☐ 26-50 ☐ 51+

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? *(if "Yes," give details, including description of duties and hours worked per week)* ☐ Yes ☐ No

____

____

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 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 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) 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

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

____
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, 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 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 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

____
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)

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. 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)*: ______

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. Request for Additional Life Policy(ies)

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

______

______

7. Underwriting Class Quoted

______

______

☐ Tobacco ☐ Nontobacco

8. 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: ______

9. Producer Remarks

______

______

______

______

10. 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 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 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 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. **False Statements in Applications:** The falsity of any answer to the questions above in Part 1 or any statement in the Application shall not bar the right to recovery under this TIA 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 Company.
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

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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.

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A. If applying for Life Insurance:

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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 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 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 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.

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2. **False Statements in Applications:** The falsity of any answer to the questions above in Part 1 or any statement in the Application shall not bar the right to recovery under this TIA 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 Company.
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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 "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

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

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 Testing Consent Form

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

The insurance company to which you have applied may request a body fluid sample from you for testing. One test will be to detect the presence of antibodies to the Human Immunodeficiency Virus (HIV). HIV is the virus which causes AIDS. California law requires an insurance company to obtain your written consent in order to test for the presence of an antigen or antibody to HIV. The results of this test may determine your eligibility to acquire insurance. By signing this form you have consented to the HIV test and the reporting of the test results to the insurance company taking your application. Positive test results will not be disclosed except as authorized by you in writing. Negative and indeterminate (inconclusive) test results may be disclosed to reinsurers, contractually retained medical personnel and insurance affiliates or subsidiaries that are involved in necessary underwriting decisions regarding your application. The insurance company and any other party receiving the negative or indeterminate test results will maintain the results of your HIV antibody test as confidential.

If your test results indicate the presence of antibodies to HIV, or if your test results cannot be accurately determined, the insurance company will report a "nonspecific abnormality" to MIB, Inc. ("MIB"). MIB contains the names and computerized medical records of insurance applicants nationally. The report will not identify you as having an abnormal HIV antibody test because many other abnormalities are reported to MIB under the same classification.

The HIV antibody test is extremely accurate. However, in rare instances the test may be positive in persons who are not infected with the virus. Additionally, the test may occasionally be negative in persons who are infected with HIV (a false negative) especially when the infection occurred within the previous 3 - 6 months.

If your antibody test is positive, it does not mean you have AIDS. A positive test indicates that you have been infected with HIV. It also means that HIV is present in your body fluids (such as blood, semen, vaginal secretions) and that you could infect other people through sexual contact, by sharing intravenous needles, by having a baby, or by donating blood, semen, or body organs. Persons who have a positive HIV antibody test should see a physician as soon as possible.

A negative test result means no antibodies to the HIV virus were found. Because of various incubation periods, absence of HIV antibodies does not mean that you have not been infected with the virus. Nor does absence of HIV antibodies mean that you are immune to the virus.

The insurance company will notify your physician if your test results are positive or if your results cannot be accurately determined. You should request that your results be sent to your private physician so that he can interpret them for you.

In the event of a positive or indeterminate test result, I authorize disclosure to the following physician:

Physician's Name: ______________________________ Address: ______________________________

____

____

____

The following organizations can provide counseling on HIV infection:

1. Cares Community Health (Sacramento area), 916.443.3299
2. San Francisco AIDS Foundation, 415.487.3000
3. AIDS Project Los Angeles, 213.201.1600
4. Any County Health Department

Informed Consent

I have read and understand this information, I voluntarily consent to the withdrawal and the testing of body fluids, and the disclosure of the test results as described above.

______________________________ ______________________________

Name of Proposed Insured | Signature of Proposed Insured

______________________________ ______________________________

Date Signed by Proposed Insured | State of Residence

FACT: There is no vaccine for HIV or a cure for AIDS.

Some medicines are now available to help people with HIV live longer, healthier lives. None of these medicines can keep a person from becoming infected with HIV. None of the treatments can cure AIDS. But people can take steps to prevent HIV infection by learning the facts and acting on them.

FACT: You can help fight the battle against HIV and AIDS by being a volunteer.

Volunteers are always needed. They can answer AIDS hotlines and help teach others about HIV and AIDS. They can help people living with HIV and AIDS by shopping for them or bringing meals to their homes. They can help raise funds to fight this epidemic. Call your local Red Cross or AIDS service organization to learn how you can help.

What can I do to help?

Know the facts about HIV and AIDS.

Use what you have learned to help protect yourself and others. Share the facts about HIV and AIDS with your family, friends, partners and co-workers.

Set an example for others.

Show support and caring for people who are living with HIV and AIDS. Remember, you can't get HIV from being a friend.

Become a volunteer.

Sponsor an AIDS fund-raising event or donate money.

Become a Red Cross HIV/AIDS instructor.

For more information, contact—

- Your local American Red Cross. To locate the one nearest you, go to *www.redcross.org*.
- The CDC National AIDS Hotline (toll free): 1-800-342-AIDS. For Spanish-speaking persons, Línea Nacional del SIDA: 1-800-344-7432. For deaf and hearing-impaired persons, TTY-TDD Hotline: 1-800-243-7889.
- The CDC National Prevention Information Network (toll free): 1-800-458-5231 or *www.cdcnpin.org*.
- The CDC Division of HIV/AIDS Prevention at *www.cdc.gov/hiv/dhap.htm*.
- Your doctor or your health provider.
- Your local or state public health department.
- Your local AIDS service organization.

American Red Cross HIV/AIDS Programs

The American Red Cross has Basic, African American, Hispanic and Workplace HIV/AIDS programs. Youth materials, including *Act SMART,* "The Party" and "Don't Forget Sherrie," are also available. Contact your local American Red Cross chapter or station for additional information.

All people share the responsibility to protect themselves and others from HIV infection.

American Red Cross

Together, we can save a life

This publication was supported by Cooperative Agreement No. U62/CCU 303031 from the Centers for Disease Control and Prevention (CDC) of the U.S. Public Health Service. Its contents are solely the responsibility of the American Red Cross and do not necessarily represent the official views of the CDC.

A1597 (April 2004)

Together, we can save a life

HIV AND AIDS

AIDS is one of the leading causes of death among Americans ages 25 to 44. Many people currently living with HIV, the virus that causes AIDS, did not believe they were at risk. HIV is serious, but HIV infection can be prevented. This brochure has important information about HIV and AIDS that will help you learn to protect yourselves and others.

FACT: AIDS is caused by a virus called HIV.

HIV stands for *human immunodeficiency virus*. It is the virus that causes AIDS—*acquired immunodeficiency syndrome*. The virus spreads from person to person through blood-to-blood and sexual contact. People with HIV have what is called HIV infection and will eventually develop AIDS as a result. AIDS is a condition caused by HIV weakening a person's immune system so much that they are not able to fight off other infections. Although treatments for HIV infection and AIDS-related illnesses have greatly improved, there is no cure and these infections may eventually lead to death.

Most people get infected with HIV by having sex or sharing needles with someone who already has the virus. **HIV does not discriminate. Anyone can get HIV.**

FACT: People infected with HIV may look and feel healthy for a long time.

People with HIV may look and feel healthy for years after becoming infected. They may not know they are infected. Even if they don't look or feel sick they can infect others. Scientists have estimated that about half the people who have HIV will develop AIDS within 10 years after becoming infected if they do not receive treatment.

FACT: When signs of illness do appear, they vary from person to person.

Symptoms vary from person to person. When symptoms do appear, they can be like those of many common illnesses and may include enlarged lymph glands, fever, weight loss and diarrhea. In some women, recurrent, hard-to-treat vaginal or oral yeast infections and cervical cancer may be related to HIV infection. When people develop AIDS, they may get illnesses that healthy people can usually resist. Only a test can tell if someone is infected with HIV. Only a doctor can diagnose AIDS.

FACT: You cannot "catch" HIV like you do a cold or flu.

HIV is not spread through the air or water. HIV is not spread through everyday casual contact.

You cannot get HIV from—

- Handshakes.
- Hugs.
- Coughs or sneezes.
- Sweat or tears.
- Mosquitoes or other insects.
- Pets.
- Eating food prepared by someone else.
- Being around an infected person.

You cannot get HIV from using—

- Swimming pools.
- Bathrooms.
- Toilet seats.
- Phones or computers.
- Straws, spoons or cups.
- Drinking fountains.

FACT: Most people with HIV or AIDS got the virus by having sex or sharing needles with someone who was already infected.

People become infected with HIV by:

- Sharing needles or syringes with someone who has the virus.
- Having vaginal, oral or anal sex with someone who has the virus.
- During pregnancy, birth or breast feeding from a mother with HIV to her baby.

FACT: You can protect yourself and others from HIV.

Not having sex is the only sure way to avoid the sexual transmission of HIV. However, if you decide to have sex, you can reduce your risk of infection in several ways:

- Have sex only with one partner who is not infected, who has sex only with you and who does not share needles or syringes. (Keep in mind that it is difficult to know these things about another person.)
- Avoid contact with your partner's blood, semen or vaginal fluid.
- Use latex (or polyurethane) condoms consistently and correctly during sex.
- Use a water-based lubricant with a latex (or polyurethane) condom for vaginal or anal sex to reduce the risk of breakage.
- Use a dental dam during oral sex to help reduce the risk of transmitting HIV or other sexually transmitted diseases.

The most effective way to prevent HIV infection through drug use is to stop injecting drugs.

People who inject drugs can reduce the risk of HIV infection by—

- Using **new**, sterile equipment every time you inject.
- Cleaning needles and syringes with bleach and water prior to injecting. Contact your local drug treatment center, health department or AIDS organization for more information on how to clean drug equipment.

FACT: It is impossible for a donor to get HIV from giving blood or plasma.

In the United States, every piece of equipment (needles, tubing, containers) used to draw blood is brand new and sterile. It is used only once, and then discarded. **You cannot get HIV from giving blood.**

FACT: The chances of getting HIV from blood transfusion in the United States are now extremely low.

Since 1985, all donated blood and plasma have been tested for signs of HIV. The tests used are more than 99 percent accurate. People who are at risk of being infected with certain germs, including HIV, are not allowed to give blood. If signs of the virus are found in donated blood, the blood is destroyed. Before 1985, some people became infected with HIV through infected blood and certain blood products used for transfusion and for treating diseases such as hemophilia.

FACT: There are tests for HIV.

If you think you may be infected with HIV, you are encouraged to seek counseling and HIV-antibody testing. Standard tests look for the presence of HIV antibodies, which are signs of the virus. The body almost always develops antibodies to fight off viruses that enter the blood stream.

Current tests are more than 99 percent accurate. However, it can take up to three months after a person becomes infected before antibodies can be detected by a test. For this reason, if someone was infected recently, the test may not yet show that the person is infected. Contact your local public health department, AIDS service organization, Red Cross chapter or station, or doctor's office for more information about HIV-antibody testing and counseling.

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

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.

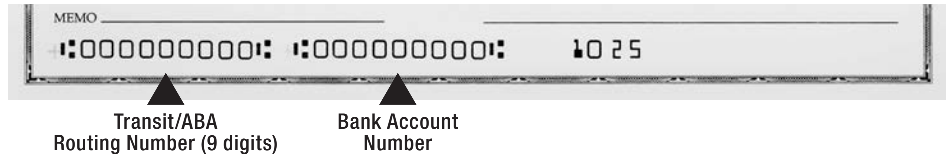
The Company indicated above, hereby requested and authorized, subject to its approval, to draw checks, drafts or orders monthly, whether by electronic or paper means, to be charged against the (check one in each column): ☐ Checking ☐ Saving | ☐ Bank ☐ Credit Union

____
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