

New Business Instruction Cover Sheet

Ameritas Life Insurance Corp. ("Company") P.O. Box 305086, Nashville, TN 37230-5086 / 800-262-2360 / Client Service Office

Producer Information		Proposed Insured Information	
Name		Name	
Producer #	Profile #	Date of Birth	
Telephone Number		Social Security Number	
Producer E-mail		Date	Number of pages being sent
If Companion Application, list Companion Name (and Policy Number, if known):			
Case Manager/Administrator		Case Manager/Administrator Email	

Product(s) being applied for: Term IUL

Medical Requirements/Parameds (if applicable): Will be ordered automatically by Ameritas based on age/face amount through Exam One (only vendor available at this time).

If you choose to order, check "Agent Order" below and understand this may add processing time.

Agent Order (*Exam One only*)

Enclosures: (check all items being submitted or to follow)

Attached	To Follow	Attached	To Follow
<input type="checkbox"/>	<input type="checkbox"/> Application	<input type="checkbox"/>	<input type="checkbox"/> Replacement / 1035 Exchange (<i>mail original</i>)
<input type="checkbox"/>	<input type="checkbox"/> Check (amount of check \$ _____)	<input type="checkbox"/>	<input type="checkbox"/> Illustration / UN 0008
<input type="checkbox"/>	<input type="checkbox"/> IR / PHI Order# _____	<input type="checkbox"/>	<input type="checkbox"/> Income Documentation
<input type="checkbox"/>	<input type="checkbox"/> EFT Form		

Comments: _____

Please Note:

- One application per submitting transmission. Do not mail original if you sent electronically or via fax.
 - Before submitting 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 305086, Nashville, TN 37230-5086
 - **Overnight Mail to** – Client Service Office, 100 Centerview Drive, Suite 100, Nashville, TN 37214
 - **Affix a copy of the check. Original must be received in 10 days.**
1. The Notice of Insurance Information Practices must be given to the client prior to completion of the application.
 2. The proposed insured and owner/trustee, if different, must sign the form where indicated.
 3. We cannot accept life insurance applications for minors younger than 15 (fifteen) days old.
 4. If the insured is a minor, then the insured's guardian should sign on the insured's signature line. If the guardian also happens to be the owner, then he/she will also need to sign on the owner's line. We need signatures on both lines.
 5. 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.
 6. If premium or Electronic Fund Transfer (EFT) authorization is obtained with the application, please review the TIA before completing the Payor section of this application as Ameritas may not be able to bind coverage or collect money subject to the terms of the TIA.
 7. **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. For further information and instructions, please refer to <http://www.irs.gov/Businesses/Corporations/FATCA-Related-Forms>.**
 8. If you learn of any adverse information after the application has been submitted and before the policy is issued or delivered, you are required to report it immediately.
 9. If a life insurance contract is being replaced, you must follow appropriate replacement procedures.

Application for Individual Life Insurance Notice of Insurance Information Practices

Ameritas Life Insurance Corp. ("Company") P.O. Box 305086, Nashville, TN 37230-5086 / 800-262-2360 / Client Service Office

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 Individual Life Insurance

Ameritas Life Insurance Corp. ("Company") P.O. Box 305086, Nashville, TN 37230-5086 / 800-262-2360 / Client Service Office

1. Proposed Insured (One)

First Name: _____ MI: ____ Last Name: _____ Suffix: _____

Address: _____

City: _____ State: _____ ZIP: _____ Years at this Address: _____

Sex: Male Female SSN or Tax ID Number: _____

Date of Birth: _____ Place of Birth (State/Country): _____ / _____

Driver's License or Government issued picture ID: _____ State: _____ Country: _____

Phone #: _____ Cell Home Work Phone #: _____ Cell Home Work

Best time to call: _____ AM PM If you are not available when we call, may we speak with your spouse? Yes No

E-mail Address: _____

Residency Status: U.S. Resident Other: _____

Are you a U.S. Citizen? Yes No (If "No," provide a copy of valid Passport and Visa)

Citizenship: _____ Visa Type: _____ Visa #: _____ Number of years residing in U.S.: _____

Employer Name: _____

Address: _____ City: _____ State: _____ ZIP: _____

Occupation: _____ Years: _____

Duties: _____

2. Proposed Insured (Child)

First Name: _____ MI: ____ Last Name: _____ Suffix: _____

Date of Birth: _____ Sex: Male Female Place of Birth (State/Country): _____ / _____

Social Security No.: _____ Driver's License No.: _____ Relationship: _____

First Name: _____ MI: ____ Last Name: _____ Suffix: _____

Date of Birth: _____ Sex: Male Female Place of Birth (State/Country): _____

Social Security No.: _____ Driver's License No.: _____ Relationship: _____

3. Owner Information (complete only if Owner is other than Proposed Insured)

Individual Trust (provide copy) Partnership Corporation – State or County of Incorporation: _____

(For Trust, Partnership, or Corporation, complete **IRS Form W-9**; For Employer-Owned Life Insurance, complete **Form UN 1166**)

First Name: _____ MI: ____ Last Name: _____ Suffix: _____

Relationship to Proposed Insured(s): _____

Trustee(s) First Name: _____ MI: ____ Last Name: _____ Suffix: _____

Date of Birth or Date of Trust: _____ SSN or Tax ID Number: _____

Driver's License or Government issued picture ID: _____ State: _____ Country: _____

Address: _____

City: _____ State: _____ ZIP: _____ Years at this Address: _____

Phone #: _____ Cell Home Work Phone #: _____ Cell Home Work

E-mail Address: _____

Residency Status: U.S. Resident Other: _____

Are you a U.S. Citizen? Yes No (If "No," provide a copy of valid Passport and Visa; and complete applicable IRS Form W-8)

Citizenship: _____ Visa Type: _____ Visa #: _____ Number of years residing in U.S.: _____

Successor Owner First Name: _____ MI: ____ Last Name: _____ Suffix: _____

SSN or Tax ID Number: _____

4. Beneficiary Unless otherwise indicated, multiple beneficiaries of the same class shall be paid equally to the survivor or survivors.

Primary Full Name(s)	%	Address: Street City / State / ZIP	Relationship to Insured	Date of Birth or Date of Trust	SSN/EIN

Total: 100%

Contingent Full Name(s)	%	Address: Street City / State / ZIP	Relationship to Insured	Date of Birth or Date of Trust	SSN/EIN

Total: 100%

5. Product Name Enter product name here: _____

Term: Specified Amount: \$ _____

Plan of Insurance: Term 10 Term 15 Term 20 Term 25 Term 30 Other: _____

Supplementary Benefits:

Accidental Death Benefit Rider . . . \$ _____ Children's Insurance Rider \$ _____

Waiver of Premium Rider Other: _____

Index Universal Life: Specified Amount (base only): \$ _____ (complete Supplemental Application for Index UL)

Death Benefit Option: Option A (Specified Amount) Option B (Specified Amount plus Account Value)

Life Insurance Qualification Test: GPT - Guideline Premium Test (Default if no option is selected) CVAT - Cash Value Accumulation Test

Supplementary Benefits:

Accelerated Death Benefit for Chronic, Critical and Terminal Illness Rider, select one Residual Death Benefit option:

Waiver of Monthly Deduction Options:

Option 1: Waiver of Monthly Deductions 0 months (default, no charge option)

Residual Death Benefit Options:

Option 1: Residual Death Benefit 10% (default, no charge option)

Option 2: Residual Death Benefit 20% (for charge option)

Accidental Death Benefit Rider . . . \$ _____

Children's Insurance Rider \$ _____

Early Cash Value Rider \$ _____

Guaranteed Insurability Rider . . . \$ _____

Lifetime Income Rider

Supplemental Coverage Rider . . . \$ _____

Waiver of Specified Premium Rider . \$ _____

Other: _____

6. Payor a. Payor Information: Insured Owner Other: *(provide details)*

Name: _____
 Address: _____
 City, State, ZIP: _____
 Relationship: _____
 Purpose: _____

b. Premium Billing Method: Electronic Fund Transfer (EFT) - Complete EFT form Direct Bill
 Single Premium Other: _____

c. Premium Frequency: Annual Semi-Annual Quarterly Monthly *(Not available for Direct Bill)*

d. Has any premium been given in connection with this application? Yes \$ _____ *(complete Temporary Insurance Agreement)*
 No

Check here if this is a request for a **one-time** initial draft of the direct modal premium.

e. Planned Periodic Premium *(modal) (Flexible Premium Plans only)*: \$ _____

f. Additional First-Year Premium *(lump sum amounts) (Flexible Premium Plans only)*: \$ _____

7. Electronic Delivery Authorization *If no election is made, the default will be "No."*

Do you consent to electronic delivery of documents? Yes No

My e-mail address is: _____

You have the right to revoke your consent at any time by calling us at the phone number provided on this application. Your consent will be effective until you revoke it.

Electronic delivery will include: policy, annual and/or quarterly policy reports; and additional documents as they become available in the future.

I (We) will notify the Company of any new e-mail address. I (We) understand that if consent for electronic delivery is given, but a legible e-mail address is not provided in this section, electronic delivery will not be initiated.

When documents are ready to be viewed electronically, you will receive an e-mail notification with a link to view the materials on our website.

Enrollment in this electronic delivery service requires that you have a personal computer with appropriate browser software, e-mail software, as well as communications access to the internet. While the Company provides such internet delivery free of charge, the size of the documents may be large. It is possible you could be charged by an Internet Service Provider or other party to receive or download such a document via the internet. Some documents are available as Portable Document Format (PDF) files requiring the use of Adobe Acrobat Reader software which is available on our website at no charge.

8. Existing and Pending Insurance - Proposed Insured(s)

a. Total life insurance in force on the proposed insured with all companies? \$ _____

b. Total life insurance currently pending, or applied for with all companies? \$ _____

c. Of the current pending, applied for coverage, both with other companies and with Ameritas, the total amount that will be placed? \$ _____

d. Will the insurance applied for on any proposed Insured discontinue, replace or change any Existing life or annuity policy? . . . Yes No
If yes, complete replacement forms, if required, and provide details below.

Proposed Insured Name	Company	Policy Type	Policy Number	Amount of Insurance	Issue Date	Replacement?
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No

Is this intended to be a 1035 Exchange? Yes No *(If yes, complete Policy Assignment Form for 1035 Exchange)*

Anticipated Cash Value Transfer: \$ _____

9. Financial Details

Income (If minor, complete for Parent/Guardian)

Proposed Insured Gross Earned Annual Income (salary, commissions, bonuses)	Proposed Insured Gross Unearned Annual Income (dividends, pensions, interest, real estate income, etc.)	Household Gross Annual Income	Household Total Net Worth
\$	\$	\$	\$

In the last 5 years, have you filed for bankruptcy? Yes No

If "Yes:" Chapter: _____ Date Opened: _____ Date Closed: _____

10. Source of Premiums

a. Check all that apply:

- | | | |
|--|---|---|
| <input type="checkbox"/> Current Income | <input type="checkbox"/> Rollover | <input type="checkbox"/> Sale of personal property or real estate |
| <input type="checkbox"/> 1035 Exchange | <input type="checkbox"/> Transfer | <input type="checkbox"/> Employer |
| <input type="checkbox"/> Insurance/Annuities
(Loans/Withdrawals) | <input type="checkbox"/> Beneficiary IRA | <input type="checkbox"/> Premium Finance |
| <input type="checkbox"/> Insurance or Annuity maturity value
or death benefit | <input type="checkbox"/> Spousal Assumption | <input type="checkbox"/> Cash Savings |
| <input type="checkbox"/> Other/Details: _____ | <input type="checkbox"/> Relative | |

b. Will this purchase be funded from a Qualified Account (liquidated within the past 60 days)? Yes No
(if "Yes," give details): _____

c. Will this purchase involve the liquidation of a Securities product? Yes No
(if "Yes," give details): _____

11. Statement of Intent

a. Have you ever sold, assigned, or pledged as collateral a life insurance policy, or an interest in a life insurance policy? Yes No
(if "Yes," give details): _____

b. Is there, or will there be, any agreement or understanding that provides for a party, other than the Owner, to obtain any interest in any policy issued on the life of the proposed insured as a result of this application? Yes No

c. Will the premiums be financed through a loan? Yes No (if "Yes," list: lender, duration of loan, and collateral required):

d. Will any entity other than a life insurance company be medically evaluating the proposed insured either to obtain financing or to determine life expectancy? Yes No (if "Yes," give details):

e. Will a captive insurance company own, control or benefit from this policy in any way? Yes No

f. Will the source of any portion of the premium payments be assets of, or from contributions to, a captive insurance company? Yes No

12. 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 contract, or any other accident and sickness insurance? Yes No (if "Yes," give details):

Company: _____ Policy 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) _____

13. Lifestyle Questions *(please provide details for "Yes" answers)*

Has any person proposed for coverage:

Proposed Insured
One

Proposed Insured
Child

- a. Used tobacco or nicotine products in any form within the last five years? Yes No Yes No
(in Details, provide dates and type: cigarettes, e-cigarettes, cigars, cigarillos, a pipe, chewing tobacco, nicotine patches, gum, etc.)
- b. Ever applied for insurance or reinstatement which has been: declined, postponed, rated, modified; or had any such insurance canceled or a renewal premium refused? Yes No Yes No
(in Details, provide date, reason, and company name)
- c. Received or claimed: indemnity, benefits, or a payment for any injury, sickness or impaired condition within the last five years? Yes No Yes No
- d. Ever made any flights, or intend to within the next two years, as: a pilot, student pilot, or crew member of any aircraft? Yes No Yes No
(if "Yes," complete Aviation Questionnaire)
- e. Been convicted of a moving traffic violation, had any traffic accidents in which you were found to be at fault, or had a driver's license revoked or suspended within the past five years? Yes No Yes No
- f. Plead guilty to, convicted of, or currently have a charge pending for the violation of any criminal law? . . Yes No Yes No
- g. In the next year, any intention of traveling outside of the U.S. or Canada, or residing outside of the U.S.? . Yes No Yes No
(if "Yes," complete Foreign Travel Questionnaire)
- h. Belong to or have entered a written agreement to become a member of: any active or reserve military, naval, or aeronautic organization? Yes No Yes No
(if "Yes," complete Military Service Questionnaire)
- i. Engaged in or plan to engage in, within the next two years, any form of the following: Yes No Yes No
(if "Yes," check all boxes below that apply and complete appropriate form(s))
 Martial Arts Motorized racing Mountain climbing Parachuting/Skydiving Scuba diving
 Other _____

Question Number	Name of Proposed Insured	Details to any "Yes" answers to Lifestyle Questions

14. Health Questions (please provide details for "Yes" answers on following page)

Proposed Insured One: _____

a. 1. Height: ___ ft. ___ in. 2. Weight: _____ lbs.

Proposed Insured Child: _____

a. 3. Height: ___ ft. ___ in. 4. Weight: _____ lbs.

- | | Proposed Insured
One | Proposed Insured
Child |
|---|--|--|
| b. Has your weight changed by more than 10 lbs. in the last twelve months?
<i>(If "Yes," list amount gained or lost and provide details.)</i> | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| c. Have you ever been told by a member of the medical profession that you have,
or been diagnosed with or treated for: | | |
| 1. High blood pressure or high cholesterol levels? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Disorder of the eyes, ears, nose or throat? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Dizziness, vertigo, fainting, seizures, recurrent headache; speech defect, tremor, neuropathy,
paralysis, multiple sclerosis, stroke, transient ischemic attack (TIA), memory loss, dementia or any
other disorder of the brain or nervous system? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Shortness of breath, chronic cough, bronchitis, asthma, emphysema,
chronic obstructive pulmonary disease (COPD), sleep apnea, or chronic respiratory disorder? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Chest pain, irregular heartbeat, heart murmur, heart valve disease, heart attack,
coronary artery disease, heart failure, aneurysm or other disorder of the heart or blood vessels? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Intestinal bleeding, inflammatory bowel disease (including Crohn's disease or ulcerative colitis),
hepatitis, diverticulitis, recurrent indigestion or other disorder of the esophagus, stomach,
intestines, pancreas, liver or gallbladder? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Sugar, protein, or blood in urine; sexually transmitted disease (excluding HIV);
chronic kidney disease, kidney stone or other disorder of the kidneys or bladder? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Diabetes, elevated blood sugar, thyroid, pituitary, adrenal or other endocrine (glandular) disorders? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 9. Disorder of the breasts, reproductive organs, or prostate? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 10. C-section, miscarriage, or complication of pregnancy? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 11. Arthritis, gout, lupus or disorder of or injury to the bones, muscles, wrists, hips, knees or other joints? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 12. Spinal, neck or back disorder or injury, including sprains, strains, or disc disorder? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 13. Mass, polyp, cyst, tumor or cancer? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 14. Allergies; disorder of the skin; anemia, bleeding, clotting or other disorder of the blood? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 15. Anxiety, depression, stress, attention deficit hyperactivity disorder (ADHD),
eating disorder or other psychiatric or mental health disorder? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 16. Chronic fatigue, chronic pain, fibromyalgia, or fever of unknown cause? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| d. Are you currently pregnant? <i>(If "Yes," list expected due date.)</i> | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| e. Other than noted above, have you within the past five years: | | |
| 1. Consulted or received treatment from a chiropractor? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Had a checkup, consultation, illness, injury, or surgery; been a patient in a hospital, rehabilitation
center or other medical facility; had an X-ray, EKG, heart scan, MRI or CT scan, biopsy or other
diagnostic test (excluding HIV)? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Been advised by a member of the medical profession to have any diagnostic test (excluding HIV),
hospitalization, or surgery which has not been completed? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| f. Within the past ten years, have you ever: | | |
| 1. Used marijuana, cocaine, heroin, barbiturates, tranquilizers, hallucinogens,
amphetamines, narcotics or any other drug, except as legally prescribed by a physician? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Sought, received or been advised to seek medical treatment,
counseling or participation in a support group for the use of alcohol or drugs? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Consumed alcoholic beverages? If yes, specify extent. | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| g. Have you been diagnosed by a member of the medical profession as having Acquired Immune
Deficiency Syndrome (AIDS) or ever tested positive for Human Immunodeficiency Virus (HIV)? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| h. Have any of your immediate family members (parents, brothers and sisters) died of or been diagnosed
as having coronary artery disease, stroke, diabetes, cancer, polycystic kidney disease or
Huntington's disease prior to age 60? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |

(please provide details for "Yes" answers on following page)

Health Questions (continued)

i. Family History: Age if Living Age at Death Cause of Death

Father _____ _____ _____

Mother _____ _____ _____

Brothers _____ _____ _____

Sisters _____ _____ _____

j. Name and address of personal or attending physician:

Telephone: _____ Date last consulted: _____

Reason for last consultation and any medication/treatment given: _____

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

Please provide details for each "Yes" answer to Health questions:

Question Number	Name of Proposed Insured/Child	Name, Address, Telephone of Personal Physician and all other Medical specialists seen (if NONE, so state)	Date Last Seen	Reason for last consultation; outcome and any medication/treatment received

15. Fraud Notice

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

16. Agreement

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

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

If applying for a Term policy, which is an indeterminate premium plan:

- a. the premium for such plan is guaranteed for the initial guaranteed 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.

Dated at: _____
City State Month Day Year

Print or Type Proposed Insured Name

Print or Type Producer Name

X

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

Producer No. Profile No. % Split

X

Signature of Producer

Print or Type Owner if not Proposed Insured

Print or Type Producer Name

X

Signature of Owner if not Proposed Insured

Producer No. Profile No. % Split

X

Signature of Producer

Application for Individual Life Insurance Authorization

Ameritas Life Insurance Corp. ("Company") P.O. Box 305086, Nashville, TN 37230-5086 / 800-262-2360 / Client Service Office

Authorization to Obtain and Disclose Information

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

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

By my signature, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, other health care provider or health plan, insurer, or other entity subject to HIPAA to release and disclose my medical record without restriction. 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 understand any information disclosed under this authorization may no longer be covered by the privacy provisions of HIPAA and may be subject to redisclosure. Statement required by 164.508(c)(2)(ii). I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). 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.

Data or facts obtained will be released only: (1) to reinsurers; (2) 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; (3) as permitted or required by law; (4) to government officials when necessary to prevent or prosecute fraud or other illegal acts; and (5) 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 such time limit, if any, permitted by applicable law in the state where the policy is delivered or issued for delivery. I also agree that a copy is as valid as the original. I, or my authorized representative, am entitled to a copy. For purposes of collecting data or facts relating to a claim for benefits, this authorization is valid for the duration of the claim. I understand that: (1) I can revoke this authorization at any time by giving written request to the Company; (2) revoking this authorization will not affect any prior action taken by the Company in reliance upon this authorization; and (3) failing to sign, or revoking this authorization may impair the Company's ability to process my application or evaluate my claim and may be a basis for denying this application or a claim for benefits.

I acknowledge receipt of the Notice of Insurance Information Practices.

Dated at: _____
City State Month Day Year

Print or Type Proposed Insured Name

Print or Type Name of Personal Representative of Proposed Insured

X

Signature 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 Individual Life Insurance Producer's Statement

Ameritas Life Insurance Corp. ("Company") P.O. Box 305086, Nashville, TN 37230-5086 / 800-262-2360 / Client Service Office

1. Background Information

a. How well acquainted are you with the purchaser?

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

b. Initial contact with purchaser?

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

2. Was this a Competitive Situation? Yes No Competing Company: _____

3. Did you receive Home Office Assistance? Yes No (*if yes, please provide details in Producer Remarks*)

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

Purpose of Insurance:

c. Personal Life Insurance: Survivor Needs/Income Replacement Education Funding Retirement Funding

Other (*specify*): _____

d. Business: Key Person Business Purchase Deferred Compensation

Split Dollar Other (*specify*): _____

e. Estate: Charitable Gift Estate Tax Other (*specify*): _____

5. Was the application signed in the owner's resident state? Yes No If "No", explain: _____

6. Discounts (*check appropriate box, if applicable*)

Same Payor Discount (*Term or Term & IUL only*). Provide existing policy numbers or insured names: _____

Employee / Producer Discount (*EE must complete Payroll Deduction Authorization form*)

Association Discount (*Ameritas approval required*) Association IPN: _____

7. Underwriting Class Quoted

Nontobacco: Preferred Plus Preferred Select Standard Rapid Standard Other/Rating _____

Tobacco: Preferred Standard Rapid Standard Other/Rating _____

8. Producer Remarks

9. 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.
- All of the sales materials used have been approved in advance by the Home Office.
- I am familiar with the Guide to Market Conduct, 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 Producer Producer No. / Profile No.

Print Full Name of Producer

Temporary Insurance Agreement

Ameritas Life Insurance Corp. ("Company") P.O. Box 305086, Nashville, TN 37230-5086 / 800-262-2360 / Client Service Office

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 applied for. This TIA does not commit the Company to issue any policy.

Opt Out. By checking this box I am opting out of having temporary coverage during the underwriting process.
(Please sign this form and return with the application)

Part 1: Questions

NO REPRESENTATIVE OF THE COMPANY IS AUTHORIZED TO ACCEPT MONEY IN CONSIDERATION FOR LIFE INSURANCE if any of the questions 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.

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

Has the Proposed Insured:

3. In the past five years:
 - a. Received treatment for, been advised to seek treatment for, or been diagnosed by a licensed medical professional as having a stroke, cancer, tumor, chest pain or heart attack? Yes No
 - b. Received treatment, attended a program or been counseled for alcohol or drug abuse, or been advised by a licensed medical professional to receive such treatment? Yes No
4. 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

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.

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**.

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 for which you would have qualified based on current Company occupational and financial underwriting guidelines.
2. **Contestability for Misrepresentation:** The Company may contest and void this TIA for incorrect, untrue, incomplete, or omitted statements or any other material misrepresentation in the answers to the questions above in Part 1 or in any statement in the Application.
3. **Suicide:** If a Proposed Insured dies by suicide while sane or insane or from an intentionally self-inflicted injury, the Company's liability under this TIA will be limited to a refund of the premium payment submitted with the Application.
4. **Coverage: No coverage is provided for anyone other than the Proposed Insured.**
5. **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 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 \$_____ .

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 the TIA.

X

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

X

Signature of Proposed Owner
(if other than Proposed Insured)

X

Signature of Producer

Date

Critical, Chronic And Terminal Illness Accelerated Benefit Rider Disclosure Statement

Ameritas Life Insurance Corp.

Accelerated death benefit riders are NOT long term care riders and are not intended to qualify as long term care insurance. The amount this rider will pay may NOT be enough to cover nursing home or other bills. The *owner* may use the money received from this rider for any purpose.

Benefits paid under this rider may be taxable. Some of the benefits provided by this rider are intended to be non-taxable. However, tax laws can change affecting the taxability of benefits. *We* recommend that *you* contact *your* tax advisor to assess the impact of these benefits.

This rider MAY affect Medicaid eligibility. If *you* have an accelerated death benefit rider, *you* MAY be required to receive and spend all of the available funds in your *policy* to become eligible for Medicaid or other government assistance programs.

We will accelerate the payment of the death benefit for a qualifying event subject to the provisions of the rider. The present value of accelerated death benefits will always be less than the total accelerated death benefit requested due to discounting for mortality, interest, and future premiums.

For any *critical illnesses*, you must request the accelerated death benefit within 12 months of the date of the qualifying event.

The qualifying events covered under the rider are: 1) *critical illness*; 2) *chronic illness*; and 3) *terminal illness*.

CRITICAL ILLNESS. One of the following events experienced by the *insured*:

Condition	Description
Invasive Life Threatening Cancer	<p>A definite diagnosis of a disease manifested by the presence of one or more malignant tumors and characterized by the uncontrolled growth and spread of malignant cells and the invasion of normal neighboring tissue or distant lymph node or organ metastasis. Types of cancer include carcinoma, melanoma, leukemia, lymphoma, multiple myeloma, myelodysplastic syndrome, and sarcoma. The diagnosis of Invasive Life Threatening Cancer must be established according to the criteria of malignancy established by a board certified specialist acting with their specialty The American Board of Pathology after a study of the histocytologic architecture or pattern of the suspect tumor, tissue, or specimen that confirms such malignancy. The date of the histopathological examination that establishes a definite diagnosis.</p> <p>No benefit will be payable under this condition for any of the following:</p> <ul style="list-style-type: none"> (a) Pre-malignant lesions, benign tumors, polyps, or dysplasia; (b) Carcinoma in-situ; (c) Any non-melanoma skin cancer, except those with distant lymph node or organ metastasis; (d) Malignant melanoma skin cancer that is less than or equal to 1.0 mm in thickness, unless it is ulcerated or is accompanied by distant lymph node or organ metastasis; (e) Chronic lymphocytic leukemia classified as Rai Stage 0; (f) Early prostate cancer diagnosed as T1a or T1b by the AJCC Staging System without distant lymph node or metastasis; and (g) Papillary thyroid cancer or follicular thyroid cancer, or both, that is less than or equal to 2 cm in greatest diameter and is classified as T1 by the AJCC Staging System, without lymph node or distant metastasis.
Stroke	<p>A cerebrovascular incident caused by infarction or brain tissue, cerebral hemorrhage, thrombosis or embolization from an extra-cranial source and producing a measurable neurological deficit that persists for at least 30 consecutive days following the occurrence of the stroke.</p> <p>Stroke does NOT include Transient Ischemic Attacks (TIAs), Vertebro-basilar insufficiency, retinal vessel illnesses, lacunar infarcts which do not meet the definition of stroke as described above or incidental findings on neuroimaging studies.</p> <p>The diagnosis of stroke must be made by a neurologist based on documented neurological deficits and confirmatory neuroimaging studies.</p> <p>Intracerebral vascular events due to trauma are not covered.</p>
Major Heart Attack	<p>The death of a portion of the heart muscle resulting from obstruction of blood supply to the relevant area.</p> <p>Major Heart Attack does NOT include angina or the chance finding of electrocardiographic (EKG) changes indicative of a previous heart attack.</p> <p>The diagnosis of Major Heart Attack must be made by a <i>physician</i> and be based on the presence of a diagnostic elevation of cardiac enzymes or biomedical markers and the presence of chest pain and at least one of the following:</p> <ul style="list-style-type: none"> (a) new electrocardiographic (EKG) changes which support the diagnosis; (b) identification of an intracoronary thrombus by angiography; or (c) imaging evidence of a new loss of viable heart muscle or a new regional wall motion abnormality.

Condition	Description
End Stage Renal Failure	The irreversible and total failure of both kidneys in which the use of hemodialysis or peritoneal dialysis is deemed to be medically necessary. The diagnosis must be established by a Consultant Nephrologist.
Major Organ Transplant	<p>A definite diagnosis of the irreversible failure of any of the following organs or tissues:</p> <ul style="list-style-type: none"> (a) heart; (b) both lungs; (c) liver; (d) both kidneys; (e) pancreas; or (f) bone marrow. <p>Transplantation must be medically necessary, and must be documented as such by a Transplant specialist.</p> <p>The <i>insured</i> must be placed on a transplant list or have been the recipient of a heart, lungs, liver, kidneys, pancreas or bone marrow, and limited to these entities.</p>
ALS	A definite diagnosis of ALS (Amyotrophic Lateral Sclerosis) diagnosed by a Consultant Neurologist.
Blindness due to Diabetes	<p>A definite diagnosis of the total and irreversible loss of vision in both eyes solely as a result of diabetic retinopathy. The diagnosis of blindness must be made by a Consultant Ophthalmologist and be evidenced by:</p> <ul style="list-style-type: none"> (a) the corrected visual acuity being 20/200 or less in both eyes; or (b) the field of vision being less than 20 degrees in both eyes.
Paralysis of two or more limbs	The complete and permanent loss of use of two or more limbs through neurological injury for a continuous period of at least 90 days. Paralysis must be confirmed by a <i>physician</i> board certified in Neurology.
Major Burns	The definite diagnosis of burns that are a full-thickness or third-degree burn covering at least 20% of the body surface. The diagnosis must be established by a hospital unit.
Coma	<p>A profound state of unconsciousness from which the <i>insured</i> cannot be aroused to consciousness, and in which stimulation will produce no more than primitive avoidance reflexes, which last for a period of at least 96 hours, and for which period the Glasgow coma score must be 4 or less.</p> <p>A definite diagnosis of coma must be documented by evidence of a neurological deficit that is expected to last for a continuous 12-month period or longer from the date of the diagnosis to determine coma.</p> <p>Life support systems must be required throughout the period of unconsciousness as well as the following exclusions: (1) Coma secondary to any alcohol or drug abuse and/or narcotics are not covered by this definition. (2) Coma caused/prolonged due to therapeutic reasons is not included in this definition.</p>
Aplastic Anemia	<p>A definite diagnosis of a chronic persistent bone marrow failure, confirmed by biopsy, which results in anemia, neutropenia and thrombocytopenia requiring blood product transfusion, and treatment with at least one of the following:</p> <ul style="list-style-type: none"> (a) Marrow stimulating agents; (b) Immunosuppressive agents; or (c) Bone marrow transplantation. <p>The diagnosis of Aplastic Anemia must be made by a specialist.</p>
Benign Brain Tumor	A non-cancerous tumor within the cerebral tissue or the cerebral meninges resulting in permanent neurological symptoms and where open, surgical intervention is deemed medically necessary. The tumor must be confirmed by a CT scan or MRI examination of the brain. Tumors in the pituitary gland, cysts, granulomas and tumors in the cranial nerves (e.g. acoustic neuroma), or malformations in, or of, the brain substance, cerebral arteries or veins and/or the spinal cord are not covered by this definition.
Aortic Aneurysm	A definite diagnosis by a specialist that intervention is deemed medically necessary for disease or trauma to the aorta requiring either an open surgical repair with excision and replacement of the diseased or traumatized aorta with a graft or an endovascular repair with a stent graft. Aorta refers to the thoracic and abdominal aorta but not its branches.

Condition	Description
Heart Valve Replacement	A definite diagnosis determined by a specialist that surgery is medically necessary to replace any heart valve with either a natural or mechanical valve. Heart valve surgery or repair utilizing transvascular percutaneous valve procedures are not covered by this definition.
Coronary Artery Bypass Graft Surgery	A definite diagnosis by a specialist that surgery is medically necessary to correct narrowing or blockage of one or more coronary arteries with bypass graft(s). Any other surgical procedure, such as but not limited to, angioplasty, intra-arterial procedures, or trans-catheter percutaneous procedures are not covered.

CHRONIC ILLNESS. The *insured*:

- (1) is unable to perform (without hands-on assistance) at least two *activities of daily living*, and has been unable to perform them for a period of at least 90 days; or
- (2) has suffered *severe cognitive impairment* to the extent that *substantial supervision* is required to ensure the *insured's* health and safety.

TERMINAL ILLNESS. The *insured* has been certified by a *physician* as having an illness or physical condition which can reasonably be expected to result in death within 12 months after the date of certification.

PREMIUMS DUE. After payment of the accelerated death benefit, *you* are required to pay the premium necessary to keep the base policy and any attached riders in force.

We may charge an administrative fee not to exceed \$250 for processing a benefit under this rider.

Payment of an accelerated death benefit will decrease the death benefit proceeds by the amount accelerated.

The premium will be adjusted to reflect the lower death benefit remaining on the policy.

Underwriting approval is required for this rider.

X _____
Signature of Owner

X _____
Signature of Producer

Date

Date

Terminal Illness Accelerated Benefit Rider Disclosure Statement

Ameritas Life Insurance Corp.

Accelerated death benefit riders are NOT long term care riders and are not intended to qualify as long term care insurance. The amount this rider will pay may NOT be enough to cover nursing home or other bills. The *owner* may use the money received from this rider for any purpose.

Benefits paid under this rider may be taxable. Some of the benefits provided by this rider are intended to be non-taxable. However, tax laws can change affecting the taxability of benefits. *We* recommend that *you* contact *your* tax advisor to assess the impact of these benefits.

This rider MAY affect Medicaid eligibility. If *you* have an accelerated death benefit rider, *you* MAY be required to receive and spend all of the available funds in *your* policy to become eligible for Medicaid or other government assistance programs.

We will accelerate the payment of the death benefit for a qualifying event subject to the provisions of the rider. The present value of accelerated death benefits will always be less than the total accelerated death benefit requested due to discounting for mortality, interest, and future premiums.

The qualifying event covered under the rider is *terminal illness*.

TERMINAL ILLNESS. The *insured* has been certified by a *physician* as having an illness or physical condition which can reasonably be expected to result in death within 12 months after the date of certification.

PREMIUMS DUE. After payment of the accelerated death benefit, *you* are required to pay the premium necessary to keep the base policy and any attached riders in force.

We may charge an administrative fee not to exceed \$250 for processing a benefit under this rider.

Payment of an accelerated death benefit will decrease the death benefit proceeds by the amount accelerated.

The premium will be adjusted to reflect the lower death benefit remaining on the policy.

X _____
Signature of Owner

X _____
Signature of Producer

Date

Date

Notice and Consent Form for Testing Which May Include AIDS Virus (HIV) Antibody/Antigen Testing

Ameritas Life Insurance Corp. ("Company") P.O. Box 305086, Nashville, TN 37230-5086 / 800-262-2360 / Client Service Office

Examiner: _____

Address: _____

To determine your insurability, the Insurer named above (the Insurer) has requested that you provide a sample of your body fluids for testing and analysis. All tests will be performed by a licensed laboratory.

Tests will be performed to determine the presence of HIV antibodies or antigens to the Human Immunodeficiency Virus (HIV) also known as the AIDS virus. The HIV antibody test that we perform is actually a series of tests done by a medically accepted procedure. The HIV antigen test directly identifies AIDS viral particles. These tests are extremely accurate. Other tests which may be performed include determinations of cholesterol and related lipids (fats), and screening for liver and kidney disorders, diabetes and immune disorders.

All test results will be treated confidentially. They will be reported by the laboratory to the Insurer. When necessary for business reasons in connection with insurance you have or have applied for with the Insurer, the Insurer may disclose test results to others involved in the underwriting and claims review process. If the HIV test is positive, the results will be reported to the local health department or the State Department of Health, and if the Insurer is a member of MIB, Inc. ("MIB"), the Insurer may report the results in a generic code which signifies only a non-specific test abnormality. If your HIV test is normal, no report will be made about it to MIB. Other test results may be reported to MIB in a more specific manner. The organizations described in this paragraph may maintain the test results in a file or data bank. There will be no other disclosure of test results or even that the tests have been done except as may be required or permitted by law or as authorized by you.

If your HIV test results are normal, no routine notification will be sent to you. If the HIV test results are other than normal, the Insurer, your designated physician or your local Health Department will contact you. The Insurer may also contact you if there are other abnormal test results which, in the Insurer's opinion, are significant. The Insurer may ask you for the name of a physician or other health care provider to whom you may authorize disclosure and with whom you may wish to discuss the results.

Positive HIV antibody/antigen test results do not mean that you have AIDS, but that you are at significantly increased risk of developing AIDS or AIDS-related conditions. Federal authorities say that persons who are HIV antibody/antigen positive should be considered infected with the AIDS virus and capable of infecting others.

Positive HIV antibody or antigen test results or other significant blood abnormalities will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or that other policy changes may be necessary.

In the event of a positive HIV test result, I authorize the Insurer to send test results to the following physician or health care provider for post-test counseling and for Health Department reporting purposes:

Name and address of designated physician/health care provider: _____

I understand that I have the right to request and receive a copy of this authorization. A photocopy or transmitted facsimile of this form will be as valid as the original.

Proposed Insured

Date of Birth

Signature of Proposed Insured or Parent/Guardian

Date

State of Residence

Life Policy

Internal and External Replacement Form

Ameritas Life Insurance Corp. ("Company") P.O. Box 305086, Nashville, TN 37230-5086 / 800-262-2360 / Client Service Office

Policy number to be surrendered: _____

Name of Policyholder: _____ SSN/TIN Number: _____

Name of Joint Policyholder: _____ SSN/TIN Number: _____

1. For which type of policy is the policyholder applying? _____
2. Which type of policy is being replaced? _____
3. Are you the producer 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.

Producers 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 producer 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 producer in making recommendation to the client.

Date: _____
 Month Day Year

X _____
Owner Signature

X _____
Joint Owner Signature

Print or Type Name of Owner

Print or Type Name of Joint Owner

X _____
Producer Signature

Profile Number/Profile Code

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 to Applicants Regarding Replacement of Life Insurance or an Annuity

Ameritas Life Insurance Corp. ("Company") P.O. Box 305086, Nashville, TN 37230-5086 / 800-262-2360 / Client Service Office

This notice is for your benefit and is required by law.

1. If you are urged to purchase life insurance and to surrender, lapse, or in any other way change the status of existing life insurance, the agent is required to give you this notice.
2. It may not be advantageous to drop or change existing life insurance in favor of new life insurance, whether issued by the same or a different insurance company.

Some of the disadvantages are:

- a. The amount of the annual premium under an existing policy may be lower than that under a new policy having the same or similar benefits.
 - b. Generally, the initial costs of life insurance policies are charged against the cash value increases in the earlier policy years, the replacement of an old policy could result in the policyholder sustaining the burden of these costs twice.
 - c. The incontestable and suicide clauses begin anew in a new policy. This could result in a claim under a new policy being denied by the company which would have been paid under the old policy.
 - d. Existing policies may have more favorable provisions than new policies in such areas as settlement options and disability benefits.
 - e. An existing policy may have a reserve value in addition to any cash value which may be of some benefit to the insured.
 - f. The insurance company carrying your current insurance policy can often make a desired change on terms which would be more favorable than if existing insurance is replaced with new insurance.
3. It may not be advantageous to change an existing policy to reduced paid-up or extended term insurance or to borrow against its loan value beyond your expected ability or intention to repay in order to obtain funds for premiums on a new policy.
 4. There may be a situation in which a replacement policy is advantageous. You may want to receive the comments of the present insurance company before deciding this important financial matter.

I hereby acknowledge that I received the above "Notice to Applicants Regarding Replacement of Life Insurance or an Annuity" before I signed the application for the proposed new insurance.

Signature of Applicant

Date

Signature of Joint Applicant

Date

Statement by Applicant Regarding Notification of Replacement to the Replaced Insurer

I have read the "Notice to Applicants Regarding Replacement of Life Insurance or an Annuity" which was furnished to me by the agent taking the application for this policy.

(Applicant: Please sign ONE of the following statements.)

1. Please notify my present insurer(s) regarding this transaction.

Signature of Applicant

Date

Signature of Joint Applicant

Date

2. Please do not notify my present insurer(s) regarding this transaction.

Signature of Applicant

Date

Signature of Joint Applicant

Date

The signature of the applicant shall be that of the insured unless someone other than the insured is the owner of the policy. If someone other than the insured is the owner of the policy, the owner must sign. If the insured is under eighteen (18) years of age, the parent is deemed to be the owner of the policy.

Certification by the agent

I hereby certify that nothing was said or done during the sales presentation to influence the decision of the applicant regarding this statement.

Signature of Agent

Date

Insurance Agency or Agent License Number _____

Definitions

PREMIUMS: Premiums are the payments you make on the life insurance or annuity contract. They are unlike deposits in a savings or investment program because if you drop the policy, you might get back less than you paid in.

CASH SURRENDER VALUE: This is the amount of money you can get if you surrender your life insurance policy or annuity. If there is a policy loan, the cash surrender value is the difference between the cash value printed in the policy and the loan value. Not all policies have cash surrender values.

LAPSE: A life insurance policy may lapse when you do not pay the premiums within the grace period. If your policy had a cash surrender value, the insurer might change your policy to as much extended term insurance or paid-up insurance as the cash surrender value will buy. Sometimes, the policy lets the insurer borrow from the cash surrender value to pay the premiums.

SURRENDER: You surrender a life insurance policy when you either let it lapse or tell the company you want to drop it. If a policy has a cash surrender value, you can receive such values in cash if you return the policy to the company with a written request.

PLACE ON EXTENDED TERM: This means you use your cash surrender value to change your insurance to term insurance with the same insurer. In this case, the net death benefit will be the same as before but you will only be covered for a specified period of time.

BORROW POLICY LOAN VALUES: If your life insurance policy has a cash surrender value, you can usually borrow all or part of said amount from the insurer. Interest will be charged according to the terms of the policy, and if the loan and unpaid interest ever exceeds the cash surrender value the policy will be terminated. If you die, the amount of the loan and any unpaid interest due will be subtracted from the death benefits.

EVIDENCE OF INSURABILITY: This means proof that you are an acceptable risk. You have to meet the standards of the insurer regarding age, health, occupation, and such other standards as the insurer feels necessary to be eligible for coverage.

INCONTESTABLE CLAUSE: This says that after one (1) or two (2) years, according to the provisions of the contract, the insurer shall not resist a claim because you made a false or incomplete statement when you applied for the policy. During the first two (2) years, if there are false or incomplete answers on the application and the insurer discovers them, the insurer can deny a claim as if the policy has never existed.

SUICIDE CLAUSE: This says that if you commit suicide after being insured for less than two (2) years, your beneficiaries will receive only a refund of the premiums that were paid.

Electronic Fund Transfer (EFT)

Ameritas Life Insurance Corp. ("Company") P.O. Box 305086, Nashville, TN 37230-5086 / 800-262-2360 / Client Service Office

Policy Number / Product Applied for	Print Name of Insured	Initial Draft	Recurring Draft (may increase)
		\$	\$
		\$	\$
		\$	\$

Please check this box if you agree that premium may be deducted if the premium amount increases by \$15 per policy of the amount included above. Your representative will be given prior notification for any draft amount that exceeds the \$15 per policy limit.

Is this for Existing/Inforce Insurance? Yes (Complete Section 2 only) No (Complete Sections 1 and 2)

1. Initial Payment (check one in each column)

- Check:** Attaching a check for the Initial Modal Premium (All future recurring premiums will be withdrawn on the date chosen below. The check will be deposited upon receipt of the application by the Company.)
- Automatic Withdrawal:** Initial Modal Premium will be withdrawn from the account listed below when the policy is issued by the company. Future recurring payments will be based on the date chosen below.

2. Recurring Payments

Withdrawal: Monthly Quarterly Semi Annual Annual

Withdrawal Date: Withdraw on the day of the month matching the policy's effective date (default if no option is selected)
 Withdraw on a different day of the month: _____

Loan Repayment: If this is an existing policy and you want to make a loan payment, enter amount to withdraw: \$ _____
 and Mode: Monthly Quarterly Semi-annual Annual

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

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

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

Routing No. (9 digits)

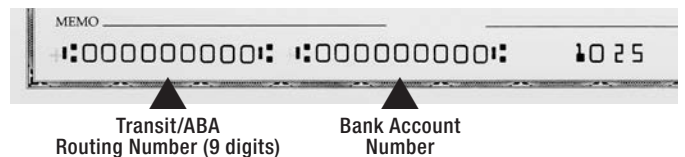
Bank Account No. (Do not include check number)

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

In some 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.

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.

X

Signature of Bank Account Holder

Date