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	
☐	☐	Application	☐	☐	Replacement / 1035 Exchange ***(mail original)***
☐	☐	Check (amount of check $ _____)	☐	☐	**Illustration / UN 0008**
☐	☐	IR / PHI Order#_____	☐	☐	Income Documentation
☐	☐	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

RESET FORM

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?
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ 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:

☐ Current Income
☐ 1035 Exchange
☐ Insurance/Annuities (Loans/Withdrawals)
☐ Insurance or Annuity maturity value or death benefit
☐ Rollover
☐ Transfer
☐ Beneficiary IRA
☐ Spousal Assumption
☐ Relative
☐ Sale of personal property or real estate
☐ Employer
☐ Premium Finance
☐ Cash Savings
☐ Other/Details: _____

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? *(in Details, provide dates and type: cigarettes, e-cigarettes, cigars, cigarillos, a pipe, chewing tobacco, nicotine patches, gum, etc.)*	☐ Yes ☐ No	☐ Yes ☐ No
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? *(in Details, provide date, reason, and company name)*	☐ Yes ☐ No	☐ Yes ☐ No
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? *(if "Yes," complete Aviation Questionnaire)*	☐ Yes ☐ No	☐ Yes ☐ No
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.?. *(if "Yes," complete Foreign Travel Questionnaire)*	☐ Yes ☐ No	☐ Yes ☐ No
h. Belong to or have entered a written agreement to become a member of: any active or reserve military, naval, or aeronautic organization? *(if "Yes," complete Military Service Questionnaire)*	☐ Yes ☐ No	☐ Yes ☐ No
i. Engaged in or plan to engage in, within the next two years, any form of the following: *(if "Yes," check all boxes below that apply and complete appropriate form(s))*	☐ Yes ☐ No	☐ Yes ☐ No

☐ 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? *(If "Yes," list amount gained or lost and provide details.)*	☐ Yes	☐ No	☐ Yes	☐ 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?	☐ Yes	☐ No	☐ Yes	☐ No
2. Disorder of the eyes, ears, nose or throat?	☐ Yes	☐ No	☐ Yes	☐ 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?	☐ Yes	☐ No	☐ Yes	☐ No
4. Shortness of breath, chronic cough, bronchitis, asthma, emphysema, chronic obstructive pulmonary disease (COPD), sleep apnea, or chronic respiratory disorder?	☐ Yes	☐ No	☐ Yes	☐ 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?	☐ Yes	☐ No	☐ Yes	☐ 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?	☐ Yes	☐ No	☐ Yes	☐ 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?	☐ Yes	☐ No	☐ Yes	☐ No
8. Diabetes, elevated blood sugar, thyroid, pituitary, adrenal or other endocrine (glandular) disorders?	☐ Yes	☐ No	☐ Yes	☐ No
9. Disorder of the breasts, reproductive organs, or prostate?	☐ Yes	☐ No	☐ Yes	☐ No
10. C-section, miscarriage, or complication of pregnancy?	☐ Yes	☐ No	☐ Yes	☐ No
11. Arthritis, gout, lupus or disorder of or injury to the bones, muscles, wrists, hips, knees or other joints?	☐ Yes	☐ No	☐ Yes	☐ No
12. Spinal, neck or back disorder or injury, including sprains, strains, or disc disorder?	☐ Yes	☐ No	☐ Yes	☐ No
13. Mass, polyp, cyst, tumor or cancer?	☐ Yes	☐ No	☐ Yes	☐ No
14. Allergies; disorder of the skin; anemia, bleeding, clotting or other disorder of the blood?	☐ Yes	☐ No	☐ Yes	☐ No
15. Anxiety, depression, stress, attention deficit hyperactivity disorder (ADHD), eating disorder or other psychiatric or mental health disorder?	☐ Yes	☐ No	☐ Yes	☐ No
16. Chronic fatigue, chronic pain, fibromyalgia, or fever of unknown cause?	☐ Yes	☐ No	☐ Yes	☐ No
d. Are you currently pregnant? *(If "Yes," list expected due date.)*	☐ Yes	☐ No	☐ Yes	☐ No
e. Other than noted above, have you within the past five years:				
1. Consulted or received treatment from a chiropractor?	☐ Yes	☐ No	☐ Yes	☐ 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)?	☐ Yes	☐ No	☐ Yes	☐ 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?	☐ Yes	☐ No	☐ Yes	☐ 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?	☐ Yes	☐ No	☐ Yes	☐ 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?	☐ Yes	☐ No	☐ Yes	☐ No
3. Consumed alcoholic beverages? If yes, specify extent.	☐ Yes	☐ No	☐ Yes	☐ 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)?	☐ Yes	☐ No	☐ Yes	☐ 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?	☐ Yes	☐ No	☐ Yes	☐ 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

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

_____
Print or Type Owner if not Proposed Insured

X _____
Signature of Owner if not Proposed Insured

_____
Print or Type Producer Name

_____ _____ _____
Producer No. Profile No. % Split

X _____
Signature of Producer

_____
Print or Type Producer Name

_____ _____ _____
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 _____ **X** _____
Signature of Proposed Insured

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	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. No benefit will be payable under this condition for any of the following: (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	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. 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. The diagnosis of stroke must be made by a neurologist based on documented neurological deficits and confirmatory neuroimaging studies. Intracerebral vascular events due to trauma are not covered.
Major Heart Attack	The death of a portion of the heart muscle resulting from obstruction of blood supply to the relevant area. Major Heart Attack does NOT include angina or the chance finding of electrocardiographic (EKG) changes indicative of a previous heart attack. The diagnosis of Major Heart Attack must be made by a *physician* 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: (a) new electrocardiographic (EKG) changes which support the diagnosis; (b) identification of an intracoronary thrombus byangiography; 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	A definite diagnosis of the irreversible failure of any of the following organs or tissues: (a) heart; (b) both lungs; (c) liver; (d) both kidneys; (e) pancreas; or (f) bone marrow. Transplantation must be medically necessary, and must be documented as such by a Transplant specialist. The *insured* 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.
ALS	A definite diagnosis of ALS (Amyotrophic Lateral Sclerosis) diagnosed by a Consultant Neurologist.
Blindness due to Diabetes	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: (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 *physician* 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	A profound state of unconsciousness from which the *insured* 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. 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. 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.
Aplastic Anemia	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: (a) Marrow stimulating agents; (b) Immunosuppressive agents; or (c) Bone marrow transplantation. The diagnosis of Aplastic Anemia must be made by a specialist.
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

_____
Date

X _____
Signature of Producer

_____
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.

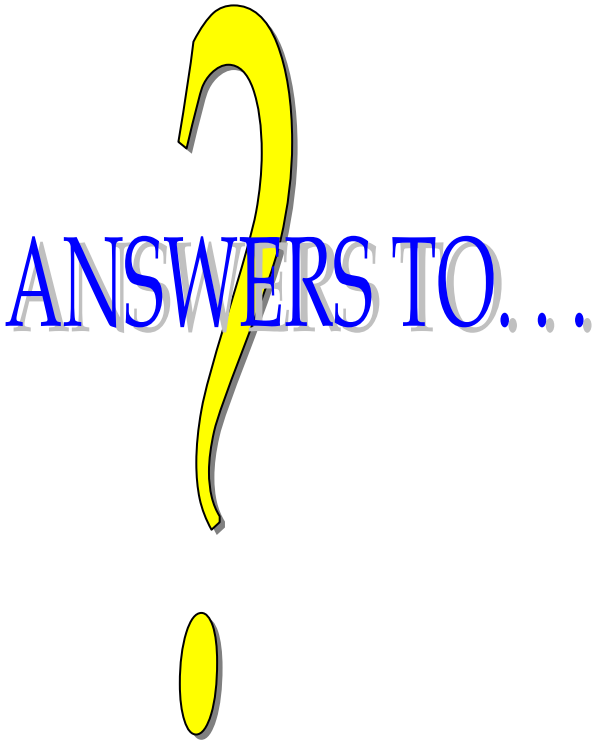
The premium will be adjusted to reflect the lower death benefit remaining on the policy.

X _____
Signature of Owner

_____
Date

X _____
Signature of Producer

_____
Date



Questions You May Have About The HIV Antibody Test

What Is The HIV Antibody Test?

The HIV antibody test is a blood test that shows if you have been infected with the **H**uman **I**mmunodeficiency **V**irus (also known as **HIV**). HIV is the virus that causes AIDS (Acquired Immune Deficiency Syndrome), a serious condition that weakens your body's ability to fight off disease. Being infected with HIV does not mean you have AIDS. It can take years for AIDS to develop in a HIV infected person, but if HIV is in your body, you can pass the virus to others.

The HIV antibody test is simple: a technician takes a blood sample from your arm and sends it to a laboratory.

The HIV antibody test is voluntary. Read all the information in this pamphlet and discuss it with your test counselor before you decide to have the test.

How Is HIV Spread?

Rich, Poor, Young, Old, Male, Female, Gay, Lesbian, Straight, Bisexual, Black, White, Asian, Hispanic, Multiracial, Married and Single. **It's not who you are that puts you at risk for HIV infection – it's what you do.**

HIV is passed from one person to another through blood, semen and vaginal fluids. Anyone who has unprotected sex or shares dirty needles with an infected person can be exposed to HIV. Infected mothers can pass the virus to their babies during pregnancy, childbirth or while breastfeeding.

You can't get HIV from mosquitoes or swimming pools. You can't get HIV by sharing dishes, toilets or workspace with an infected person. It's not spread by coughs or sneezes.

How Much Does The HIV Antibody Test Cost?

If you choose to have the HIV antibody test, there may be a charge. Be sure to ask about the cost before you agree to the testing, most health insurances cover the cost. The HIV antibody test is free to eligible individuals at locations funded by the Rhode Island Department of Health.
Call (401) 222-2320 or go the web site http://www.health.ri.gov/topics/aids.php to find out which test site is closest to you.

Who Else Will Know About The Test?

The HIV antibody test can be anonymous or confidential.

Anonymous

When you have the test done at an anonymous site, you are given a private code number. No one asks for your name. Anonymous testing is the best way to protect your privacy. If you want an anonymous test, you must let your test counselor know.

Confidential

If you have the test done in your doctor's office, hospital, clinic or any other facility, your test results may be put in your medical record. Like all your medical information, your HIV antibody test results are confidential and cannot be given to anyone without your written permission.

However, you should be aware that insurance companies and employers could sometimes gain access to your medical records. If your test shows that you have the virus, Rhode Island law allows the results to be released to certain other people and agencies, for example:

- health care providers who are treating you and
- the Department of Health (with your name attached) to track rates of HIV in the state.

If you are concerned about the confidentiality of your medical records or about the possibility that you will be discriminated against if you take the test, talk to your test counselor. You can also call the Rhode Island Commission for Human Rights at (401) 222-2661 for more information.

If you choose to have an anonymous HIV antibody test, you will give the counselor your verbal consent. If you decide to have a confidential test or choose not to have the HIV antibody test, sign the form at the end of this pamphlet.

Getting the Results – How Long Does it Take?

If your test is negative, no HIV antibodies were found in your blood. This means that you are either not infected with HIV, or you have recently been infected and it's too soon for the antibodies to show up in your blood.

If you've had unprotected sex or shared needles with someone who might be infected, you may need to be tested again in three to six months. You can protect yourself while you're waiting for another test by using condoms and/or by not sharing needles.

UN 1599 RI

If your test is positive, HIV antibodies were found in your blood. This means that you are infected with HIV. It does not necessarily mean that you have AIDS. It can take many years for AIDS to develop in an HIV-infected person.

How Will The HIV Antibody Test Help Me?

It will help you to know if you have HIV. If your test is negative, you can stop worrying and take steps to protect yourself from HIV.

If you are pregnant –

or thinking of becoming pregnant – it's important to find out if you've been infected by HIV. New studies have shown that taking HIV medications during pregnancy may greatly lower the chances of passing HIV to your baby.

If your test is positive, here's what to do:

- get medical treatment so you can live a longer, healthier life;
- find a support group to help you, your family and your partner deal with the stress;
- get information about services for HIV-positive people;
- protect your baby if you are pregnant or a new mother;
- avoid passing HIV to other by using condoms and not sharing needles; and
- ask your partner(s) to get tested and/or stay in treatment.

If you cannot afford to pay for medical care, you may qualify for free medicine. Ask your test counselor about the RI AIDS Drug Assistance Program (ADAP) or go to the web site http://www.health.ri.gov/topics/aids.php .

If your test is positive, it is very important that your contacts be tested, too. If you don't want to tell the people with whom you've had sex or shared needles about your test results yourself, the Partner Notification Program can help. A partner notification counselor will tell your partner(s) that they have been exposed to HIV without using your name.

For more information about this program, ask your test counselor, call the Rhode Island Department of Health at (401) 222-2320 or go to the web site http://www.health.ri.gov/topics/aids.php.

For More Information About HIV you can call:

The Rhode Island Department of Health
Office of HIV/AIDS & Viral Hepatitis

at **401-222-2320**
or
go to the Rhode Island HIV/AIDS website at
www.health.ri.gov/topics/AIDS
or
Rhode Island Project AIDS Hotlines
at 1-800-726-3010
or
one of the following National AIDS Hotline
1-800-342-2437 (English)
1-800-344-7432 (Spanish)
1-800-243-7889 (TDD/TTY)

INFORMED CONSENT FORM

I have been informed about HIV and the HIV antibody test. I have had an opportunity to talk with a test counselor about HIV and the HIV antibody test. I understand that no one can make me take the HIV antibody test without my consent.

☐ Yes, I give permission for my blood to be tested for the presence of HIV antibodies.

☐ No, I do not give permission for my blood to be tested for the presence of HIV antibodies.

Name:_____ Date:_____

Witness:_____ Date:_____

LFM 2/2007

A Publication of the
Rhode Island Department of Health
Office of HIV /AIDS & Viral Hepatitis

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.

Appendix A

Important Notice: Replacement of Life Insurance or Annuities

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

This document must be signed by the applicant and the producer, if there is one, and a copy left with the applicant.

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interests. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on the back of this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? ☐ Yes ☐ No
2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? ☐ Yes ☐ No

If you answered "yes" to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured or annuitant, and the policy or contract number if available) and whether each policy or contract will be replaced or used as a source of financing.

	Insurer Name	Contract or Policy #	Insured or Annuitant	Replaced (R) or Financing (F)
1.				☐ R ☐ F
2.				☐ R ☐ F
3.				☐ R ☐ F

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. If you request one, an in-force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer. Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

The existing policy or contract is being replaced because _____

I certify that the responses herein are, to the best of my knowledge, accurate:

_____ _____
Applicant's Signature and Printed Name Date

_____ _____
Joint Applicant's Signature and Printed Name Date

_____ _____
Producer's Signature and Printed Name Date

Initial

I do not want this notice read aloud to me. _____ (Applicant/s must initial only if they do not want the notice read aloud.)

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or agent that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense:

Premiums

- Are they affordable?
- Could they change?
- You're older — are premiums higher for the proposed new policy?
- How long will you have to pay premiums on the new policy? On the old policy?

Policy values

- New policies usually take longer to build cash values and to pay dividends.
- Acquisition costs for the old policy may have been paid; you will incur costs for the new one.
- What surrender charges do the policies have?
- What expense and sales charges will you pay on the new policy?
- Does the new policy provide more insurance coverage?

Insurability

- If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down.
- You may need a medical exam for a new policy.
- Claims on most new policies for up to the first two years can be denied based on inaccurate statements.
- Suicide limitations may begin anew on the new coverage.

If you are keeping the old policy as well as the new policy

- How are premiums for both policies being paid?
- How will the premiums on your existing policy be affected?
- Will a loan be deducted from death benefits?
- What values from the old policy are being used to pay premiums?

If you are surrendering an annuity or interest sensitive life product

- Will you pay surrender charges on your old contract?
- What are the interest rate guarantees for the new contract?
- Have you compared the contract charges or other policy expenses?

Other issues to consider for all transactions

- What are the tax consequences of buying the new policy?
- Is this a tax-free exchange? (See your tax advisor.)
- Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code?
- Will the existing insurer be willing to modify the old policy?
- How does the quality and financial stability of the new company compare with your existing company?

Statement Identifying Use of Home Office Approved Sales Material

The following pre-printed or electronically presented sales materials and individual sales materials, including illustrations, were used in conjunction with the sale of this policy.

Proposed Insured Name: _____

Form Number*	Title of Sales Material

***NOTE: When illustration is used, indicate N/A under Form Number and indicate "Illustration" under Title of Sales Material. All illustrations used must be attached.**

Soliciting Agent: _____

Soliciting Agent Number: _____

Date: _____

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 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

Routing No. *(9 digits)*

Bank Account No. *(Do not include check number)*

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.

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

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