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

Individual Life Insurance Supplemental Application for Index UL

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

Allocation Instructions:

_____% Fixed Account: a current interest rate.

_____% S&P 500 – Capped with 100% participation rate 1-year Point-to-Point.

_____% S&P 500 – Capped with adjustable participation rate 1-year Point-to-Point.

_____% S&P 500 – Capped with 100% participation rate 2-year Point-to-Point.

_____% Russell 2000 – Capped with 100% participation rate 1-year Point-to-Point.

_____% BNP MMA 5 – Uncapped with adjustable participation rate 1-year Point-to-Point.

_____% BNP MMA 5 – Uncapped with adjustable participation rate 2-year Point-to-Point.

100 % Total

Account value in each Index Option will renew into new participation accounts in that same Index Option at the end of each index period.

Dollar Cost Averaging

Dollars From: $_____ Fixed Account

To: _____% S&P 500 – Capped with 100% participation rate 1-year Point-to-Point.

_____% S&P 500 – Capped with adjustable participation rate 1-year Point-to-Point.

_____% S&P 500 – Capped with 100% participation rate 2-year Point-to-Point.

_____% Russell 2000 – Capped with 100% participation rate 1-year Point-to-Point.

_____% BNP MMA 5 – Uncapped with adjustable participation rate 1-year Point-to-Point.

_____% BNP MMA 5 – Uncapped with adjustable participation rate 2-year Point-to-Point.

Ameritas Life is instructed to transfer the amount(s) designated above from the Fixed Account to the selected Index Option(s). Transfers will occur monthly and will begin as of the index date after the receipt by the Client Service Office of this request. Minimum transfer is $100.

Telephone Transfer Authorization *If no election is made, the default will be "No."*

I hereby authorize and direct the Company to make allowable transfers of funds or reallocation of premiums among available Index Options based upon instructions received by telephone from: a) myself, as Owner; b) my Producer; and c) the person(s) named below. The Company will not be liable for following instructions communicated by telephone that it reasonably believes to be genuine. The Company will employ reasonable procedures, including requiring the policy number to be stated, recording all instructions received by telephone, and mailing written confirmations. If the Company does not employ reasonable procedures to confirm that instructions communicated are genuine, the Company may be liable due to unauthorized or fraudulent instructions.

If no election is made, the default will be "No."

a. Do you elect to have telephone transfer authorization? ☐ Yes ☐ No

b. Do you allow your Producer to have telephone transfer authorization? ☐ Yes ☐ No

c. Provide the following information for <u>additional</u> person(s) you wish to have telephone transfer authorization:

Name _____ SSN _____

Address _____

I understand: a) all telephone transactions will be recorded; and b) this authorization will remain in force until the authorization is revoked by either the Company or me. The revocation is effective when received in writing or by telephone by the other party.

I acknowledge receipt of Notice of Insurance Information Practices.

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.

Dated at: _____
City State Month Day Year

X _____
Signature of Owner

X _____
Signature of Joint Owner (if applicable)

X _____
Signature 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

Life Insurance Buyer's Guide

This guide can help you when you shop for life insurance. It discusses how to:

- Find a Policy That Meets Your Needs and Fits Your Budget
- Decide How Much Insurance You Need
- Make Informed Decisions When You Buy a Policy

Prepared by the National Association of Insurance Commissioners

The National Association of Insurance Commissioners is an association of state insurance regulatory officials. This association helps the various Insurance Departments to coordinate insurance laws for the benefit of all consumers.

This guide does not endorse any company or policy.

Reprinted by:
Ameritas Life Insurance Corp.
P.O. Box 81889
Lincoln, NE 68501-1889

IMPORTANT THINGS TO CONSIDER

1. Review your own insurance needs and circumstances. Choose the kind of policy that has benefits that most closely fit your needs. Ask an agent or company to help you.

2. Be sure that you can handle premium payments. Can you afford the initial premium? If the premium increases later and you still need insurance, can you still afford it?

3. Don't sign an insurance application until you review it carefully to be sure all the answers are complete and accurate.

4. Don't buy life insurance unless you intend to stick with your plan. It may be very costly if you quit during the early years of the policy.

5. Don't drop one policy and buy another without a thorough study of the new policy and the one you have now. Replacing your insurance **may be costly.**

6. Read your policy carefully. Ask your agent or company about anything that is not clear to you.

7. Review your life insurance program with your agent or company every few years to keep up with changes in your income and your needs.

BUYING LIFE INSURANCE

When you buy life insurance, you want coverage that fits your needs.

First, decide how much you need - and for how long - and what you can afford to pay. Keep in mind the major reason you buy life insurance is to cover the financial effects of unexpected or untimely death. Life insurance can also be one of many ways you plan for the future.

Next, learn what kinds of policies will meet your needs and pick the one that best suits you.

Then, choose the combination of policy premium and benefits that emphasizes protection in case of early death, or benefits in case of long life, or a combination of both.

It makes good sense to ask a life insurance agent or company to help you. An agent can help you review your insurance needs and give you information about the available policies. If one kind of policy doesn't seem to fit your needs, ask about others.

This guide provides only basic information. You can get more facts from a life insurance agent or company or from your public libarary.

WHAT ABOUT THE POLICY YOU HAVE NOW?

If you are thinking about dropping a life insurance policy, here are some things you should consider:

- If you decide to replace your policy, don't cancel your old policy until you have received the new one. You then have a minimum period to review your new policy and decide if it is what you wanted.

- It may be costly to replace a policy. Much of what you paid in the early years of the policy you have now, paid for the company's cost of selling and issuing the policy. You may pay this type of cost again if you buy a new policy.

- Ask your tax advisor if dropping your policy could affect your income taxes.

- If you are older or your health has changed, premiums for the new policy will often be higher. You will not be able to buy a new policy if you are not insurable.
- You may have valuable rights and benefits in the policy you now have that are not in the new one.
- If the policy you have now no longer meets your needs, you may not have to replace it. You might be able to change your policy or add to it to get the coverage or benefits you now want.
- At least in the beginning, a policy may pay no benefits for some causes of death covered in the policy you have now.

In all cases, if you are thinking of buying a new policy, check with the agent or company that issued you the one you have now. When you bought your old policy, you may have seen an illustration of the benefits of your policy. Before replacing your policy, ask your agent or company for an updated illustration. Check to see how the policy has performed and what you might expect in the future, based on the amounts the company is paying now.

HOW MUCH DO YOU NEED?

Here are some questions to ask yourself:

- How much of the family income do I provide? If I were to die early, how would my survivors, especially my children, get by? Does anyone else depend on me financially, such as a parent, grandparent, brother or sister?
- Do I have children for whom I'd like to set aside money to finish their education in the event of my death?
- How will my family pay final expenses and repay debts after my death?
- Do I have family members or organizations to whom I would like to leave money?
- Will there be estate taxes to pay after my death?
- How will inflation affect future needs?

As you figure out what you have to meet these needs, count the life insurance you have now, including any group insurance where you work or veteran's insurance. Don't forget Social Security and pension plan survivor's benefits. Add other assets you have: savings, investments, real estate and personal property. Which assets would your family sell or cash in to pay expenses after your death?

WHAT IS THE RIGHT KIND OF LIFE INSURANCE?

All policies are not the same. Some give coverage for your lifetime and others cover you for a specific number of years. Some build up cash values and others do not. Some policies combine different kinds of insurance, and others let you change from one kind of insurance to another. Some policies may offer other benefits while you are still living. Your choice should be based on your needs and what you can afford.

There are two basic types of life insurance: **term insurance** and **cash value insurance**. Term insurance generally has lower premiums in the early years, but does not build up cash values that you can use in the future. You may combine cash value life insurance with term insurance for the period of your greatest need for life insurance to replace income.

Term Insurance covers you for a term of one or more years. It pays a death benefit only if you die in that term. Term insurance generally offers the largest insurance protection for your premium dollar. It generally does not build up cash value.

You can renew most term insurance policies for one or more terms even if your health has changed. Each time you renew the policy for a new term, premiums may be higher. Ask what the premiums will be if you continue to renew the policy. Also ask if you will lose the right to renew the policy at some age. For a higher premium, some companies will give you the right to keep the policy in force for a guaranteed period at the same price each year. At the end of that time you may need to pass a physical examination to continue coverage, and premiums may increase.

You may be able to trade many term insurance policies for a cash value policy during a conversion period - even if you are not in good health. Premiums for the new policy will be higher than you have been paying for the term insurance.

Cash Value Life Insurance is a type of insurance where the premiums charged are higher at the beginning than they would be for the same amount of term insurance. The part of the premium that is not used for the cost of insurance is invested by the company and builds up a cash value that may be used in a variety of ways. You may borrow against a policy's cash value by taking a policy loan. If you don't pay back the loan and the interest on it, the amount you owe will be subtracted from the benefits when you die, or from the cash value if you stop paying premiums and take out the remaining cash value. You can also use your cash value to keep insurance protection for a limited time or to buy a reduced amount without having to pay more premiums. You also can use the cash value to increase your income in retirement or to help pay for needs such as a child's tuition without canceling the policy. However, to build up this cash value, you must pay higher premiums in the earlier years of the policy. Cash value life insurance may be one of several types; whole life, universal life and variable life are all types of cash value insurance.

Whole Life Insurance covers you for as long as you live if your premiums are paid. You generally pay the same amount in premiums for as long as you live. When you first take out the policy, premiums can be several times higher than you would pay initially for the same amount of term insurance. But they are smaller than the premiums you would eventually pay if you were to keep renewing a term policy until your later years.

Some whole life policies let you pay premiums for a shorter period such as 20 years, or until age 65. Premiums for these policies are higher since the premium payments are made during a shorter period.

Universal Life Insurance is a kind of flexible policy that lets you vary your premium payments. You can also adjust the face amount of your coverage. Increases may require proof that you qualify for the new death benefit. The premiums you pay (less expense charges) go into a policy account that earns interest. Charges are deducted from the account. If your yearly premium payment plus the interest your account earns is less than the charges, your account value will become lower. If it keeps dropping, eventually your coverage will end. To prevent that, you may need to start making premium payments, or increase your premium payments, or lower your death benefits. Even if there is enough in your account to pay the premiums, continuing to pay premiums yourself means that you build up more cash value.

Variable Life Insurance is a kind of insurance where the death benefits and cash values depend on the investment performance of one or more separate accounts, which may be invested in mutual funds or other investments allowed under the policy. Be sure to get the prospectus from the company when buying this kind of policy and STUDY IT CAREFULLY. You will have higher death benefits and cash value if the underlying investments do well. Your benefits and cash value will be lower or may disappear if the investments you chose didn't do as well as you expected. You may pay an extra premium for a guaranteed death benefit.

LIFE INSURANCE ILLUSTRATIONS

You may be thinking of buying a policy where cash values, death benefits, dividends or premiums may vary based on events or situations the company does not guarantee (such as interest rates). If so, you may get an illustration from the agent or company that helps explain how the policy works. The illustration will show how the benefits that are not guaranteed will change as interest rates and other factors change. The illustration will show you what the company guarantees. It will also show you what *could* happen in the future. Remember that nobody knows what will happen in the future. You should be ready to adjust your financial plans if the cash value doesn't increase as quickly as shown in the illustration. You will be asked to sign a statement that says you understand that some of the numbers in the illustration are not guaranteed.

FINDING A GOOD VALUE IN LIFE INSURANCE

After you have decided which kind of life insurance is best for you, compare similar policies from different companies to find which one is likely to give you the best value for your money. A simple comparison of the premiums is not enough. There are other things to consider. For example:

- Do premiums or benefits vary from year to year?
- How much do the benefits build up in the policy?
- What part of the premiums or benefits is not guaranteed?
- What is the effect of interest on money paid and received at different times on the policy?

Remember that no one company offers the lowest cost at **all** ages for **all** kinds and amounts of insurance. You should also consider other factors:

- How quickly does the cash value grow? Some policies have low cash values in the early years that build quickly later on. Other policies have a more level cash value build-up. A year-by-year display of values and benefits can be very helpful. (The agent or company will give you a policy summary or an illustration that will show benefits and premiums for selected years.)
- Are there special policy features that particularly suit your needs?
- How are nonguaranteed values calculated? For example, interest rates are important in determining policy returns. In some companies increases reflect the average interest earnings on all of that company's policies regardless of when issued. In others, the return for policies issued in a recent year, or a group of years, reflects the interest earnings on that group of policies; in this case, amounts paid are likely to change more rapidly when interest rates change.

Accelerated Death Benefit For Chronic, Critical And Terminal Illness 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 this rider. The accelerated payment is referred to as an accelerated death benefit. For any *critical illnesses, you* must request an accelerated death benefit within 12 months of the date of the qualifying event.

QUALIFYING EVENTS. There are 17 conditions, classified under three illnesses, which constitute qualifying events covered under this rider.

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.

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.

Condition	Description
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.
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.

Condition	Description
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.
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.

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 an accelerated death benefit, *you* are required to pay the premium necessary to keep the base policy and any attached riders in force.

The accelerated death benefit plus any administrative fee plus accrued interest will be a lien against the death benefit proceeds, not against any policy *cash surrender value*. After an accelerated death benefit has been paid both your access to the *cash surrender value* and policy lapse benefits will be restricted to the excess of the *cash surrender value* over any lien balance. On the date of death, the death benefit proceeds will be reduced by the amount of any lien balance and any *loan balance*.

We may charge an administrative fee not to exceed $250 for processing a benefit under this rider. The fee will be added to the lien at the time an accelerated death benefit is paid.

In addition to the administrative fee, there may be a monthly charge for this rider depending on the level of the Residual Death Benefit amount and the Waiver of Monthly Deduction period elected by the policy owner. Any additional monthly charge for this rider will be shown on the policy schedule.

Payment of an accelerated death benefit will decrease the death benefit proceeds by the following:

(1) the amount of an accelerated death benefit paid; plus

(2) any administrative fee and any charges associated with this rider; plus

(3) interest, as defined in the rider, on the amount of an accelerated death benefit paid plus any administrative fee.

When an accelerated death benefit is paid under this rider, an accelerated death benefit payment will be first used to repay a portion of any outstanding *loan balance* under the policy. The portion to be repaid will be determined by the product of the *loan balance* and the amount of an accelerated death benefit payment divided by the *eligible amount* under the policy as of the date an accelerated death benefit is paid. The remaining accelerated death benefit will be paid to *you*.

Underwriting approval is required for this rider.

X _____
Signature of Owner

_____
Date

X _____
Signature of Producer

_____
Date

Accelerated Death Benefit For Terminal Illness 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 this rider. The accelerated payment is referred to as an accelerated death benefit.

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 an accelerated death benefit, *you* are required to pay the premium necessary to keep the base policy and any attached riders in force.

The accelerated death benefit plus any administrative fee plus accrued interest will be a lien against the death benefit proceeds, not against any policy *cash surrender value*. After an accelerated death benefit has been paid both your access to the *cash surrender value* and policy lapse benefits will be restricted to the excess of the *cash surrender value* over any lien balance. On the date of death, the death benefit proceeds will be reduced by the amount of any lien balance and any *loan balance*.

We may charge an administrative fee not to exceed $250 for processing a benefit under this rider. The fee will be added to the lien at the time an accelerated death benefit is paid.

Payment of an accelerated death benefit will decrease the death benefit proceeds by the following:

(1) the amount of an accelerated death benefit paid; plus

(2) any administrative fee; plus

(3) interest, as defined in the rider, on the amount of an accelerated death benefit paid plus any administrative fee.

When an accelerated death benefit is paid under this rider, an accelerated death benefit payment will be first used to repay a portion of any outstanding *loan balance* under the policy. The portion to be repaid will be determined by the product of the *loan balance* and the amount of an accelerated death benefit payment divided by the *eligible amount* under the policy as of the date an accelerated death benefit is paid. The remaining accelerated death benefit will be paid to *you*.

Underwriting approval is required for this rider.

X _____
Signature of Owner

_____
Date

X _____
Signature of Producer

_____
Date

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

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

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

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

What can I do to help?

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

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

Become a volunteer.

Sponsor an AIDS fund-raising event or donate money.

Become a Red Cross HIV/AIDS instructor.

For more information, contact—

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

American Red Cross HIV/AIDS Programs

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

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

American Red Cross
Together, we can save a life

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A1597 (April 2004)

American Red Cross
Together, we can save a life

HIV AND AIDS

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

FACT: AIDS is caused by a virus called HIV.

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

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

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

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

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

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

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

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

You cannot get HIV from—

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

You cannot get HIV from using—

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

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

People become infected with HIV by:

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

FACT: You can protect yourself and others from HIV.

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

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

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

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

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

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

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

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

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

FACT: There are tests for HIV.

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

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

Informed Consent for HIV Testing

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

To evaluate your insurability, the Insurer named above (the Insurer) has requested that you provide a sample of your bodily fluid(s) for testing and analysis. These tests may include but are not limited to: tests for cholesterol and related lipids; diabetes; liver or kidney disorders; or the presence of medications, drugs, nicotine or their metabolites. The tests will be done by a certified laboratory through a medically accepted procedure which is extremely reliable.

If an HIV Antibody Screen is performed, it will be performed according to the following medical protocol: an initial ELISA test; if the initial ELISA test is positive, it is repeated; if it is negative, a negative finding is reported by the laboratory to the Insurer. If the second ELISA test is positive, a Western Blot test is used to confirm the previous positive results. If the second ELISA test is negative, a third ELISA test is performed. If the third ELISA test is positive, a Western Blot test is used to confirm the previous positive tests. If the third ELISA test is negative, a negative result is reported to the Insurer. Only if at least two ELISA tests and a Western Blot test are positive, will the result be reported as positive. All other results will be reported as negative to the Insurer. No routine notification will be sent to you if your test results are negative.

Many public health organizations have recommended that before taking an AIDS-related blood test a person seek counseling to become informed concerning the implications of such a test. You may wish to consider counseling, at your expense, prior to being tested. A list of local agencies and organizations available in your area for pre-test counseling is attached to this notice and consent form. This is not a complete list. We suggest you contact your physician, your county health department or your local chapter of the American Red Cross for further information.

The test is not a test for AIDS. It is a test for antibodies to the HIV virus, the causative agent for AIDS, and shows whether you have been exposed to the virus.

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. A positive HIV antibody test result means that your application may be declined, that an increased premium may be charged, or that other policy changes may be necessary.

A negative result means no antibodies to the HIV virus were found. Because of varying incubation periods, absence of HIV antibodies does not mean that you have not been infected with the virus. Absence of HIV antibodies does not mean that you cannot get the virus in the future.

All test results will be treated confidentially. Without a court order or a written authorization from you, these results will be made known only to the Insurer and/or its reinsurers (if involved in the underwriting process). Access will be limited to persons involved in handling or determining applications for coverage or claims of the applicant or claimant and to your health care provider or, if none is identified, to the local health department. The Insurer will provide results of all tests to a physician of your choice. In addition, the Insurer may make a brief report to MIB, Inc., in the manner described in the prenotice which you received as part of the application process. These organizations will be the only ones maintaining this information in any type of file except as required by law.

In the event of a positive or indeterminate HIV test, post-test counseling is required and must be provided to you at the time you are given the test results. The Insurer is prohibited by law from furnishing positive or indeterminate test results directly to you. Accordingly, please furnish the name and address of a health care provider or health care agency who should be informed in the event of a positive or indeterminate test.

HEALTH CARE PROVIDER OR AGENCY

Name _____

Address _____

_____

If no health care provider is designated, the results will be sent to the state or local health department for interpretation and post-test counseling.

CONSENT

I have read and I understand this Informed Consent for HIV Testing. I voluntarily consent to providing a sample of my bodily fluid(s), the testing of my bodily fluid(s) and the disclosure of the test results as described above.

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

Dated at: _____
City State

_____ _____
Proposed Insured Name Date of Birth

_____ _____ _____
Signature of Proposed Insured or Parent/Guardian Date Signed State of Residence

WASHINGTON STATE (HIV) ANTIBODY TESTING/COUNSELING SERVICES

ADAMS COUNTY HEALTH DEPARTMENT
425 E. Main St., Ste. 700
Othello, WA 99344
(509) 488-2031

ASOTIN COUNTY HEALTH DISTRICT
431 Elm St.
Clarkston, WA 99403
(509) 243-3344

BENTON-FRANKLIN HEALTH DISTRICT
7102 W. Okanogan Pl.
Kennewick, WA 99336
(509) 460-4200 (Kennewick)
(509) 547-9737 (Pasco)

CHELAN-DOUGLAS COUNTY HEALTH DISTRICT
200 Valley Mall Pkwy.
E. Wenatchee, WA 98802
(509) 886-6400

CLALLAM COUNTY HEALTH DEPARTMENT
223 E. Fourth St., Ste. 14
Port Angeles, WA 98362
(360) 417-2274

COLUMBIA COUNTY HEALTH DISTRICT
270 E Main St.
Dayton, WA 99328
(509) 382-2181

COWLITZ HEALTH DEPARTMENT
900 Ocean Beach Hwy, #1B
Longview, WA 98632
(360) 414-5599

GARFIELD COUNTY HEALTH DISTRICT
121 S. 10th St.
Pomeroy, WA 99347
(509) 843-3412

GRANT COUNTY HEALTH DISTRICT
1st and C St., NW
P.O. Box 37
Ephrata, WA 98823
(509) 754-6060

GRAYS HARBOR COUNTY HEALTH DEPARTMENT
2109 Sumner Ave.
Aberdeen, WA 98520
(360) 532-8631

ISLAND COUNTY HEALTH DEPARTMENT
410 N. Main St.
Coupeville, WA 98239
(360) 679-7351

JEFFERSON COUNTY HEALTH DEPARTMENT
615 Sheridan St.
Port Townsend, WA 98368
(360) 385-9400

KITSAP COUNTY HEALTH DEPARTMENT
345 6th St., Ste. 300
Bremerton, WA 98337
(360) 337-5235

KITTITAS COUNTY HEALTH DEPARTMENT
507 Nanum St., Ste. 102
Ellensburg, WA 98926
(509) 962-7515

LEWIS COUNTY HEALTH DISTRICT
360 N.W. North St.
Chehalis, WA 98532
(360) 740-1223

LINCOLN COUNTY HEALTH DEPARTMENT
90 Nichols St.
Davenport, WA 99122
(509) 725-1001

MASON COUNTY HEALTH DEPARTMENT
415 N 6th St.
Shelton, WA 98584
(360) 427-9670, Ext. 400

NORTHEAST TRI-COUNTY HEALTH DISTRICT
240 E. Dominion Ave.
Colville, WA 99114
(509) 684-5048

OKANOGAN COUNTY HEALTH DISTRICT
1234 2nd Ave. S.
Okanogan, WA 98840
(509) 422-7140

PACIFIC COUNTY HEALTH DEPARTMENT
1216 W. Robert Bush Dr.
South Bend, WA 98586
(360) 875-9343

SAN JUAN COUNTY HEALTH DEPARTMENT
P.O. Box 607, 145 Rhone St.
Friday Harbor, WA 98250
(360) 378-4474

SEATTLE GAY CLINIC
500 19th Ave. East
Seattle, WA 98112
(206) 299-1623

LOW RISK TESTING SITES (SEATTLE-KING CO.)

A) NORTH SEATTLE PUBLIC HEALTH CENTER
10501 Meidian Ave. North
Seattle, WA 98133
(206) 296-4990

B) RENTON PUBLIC HEALTH CENTER
3001 N.E. 4th St.
Renton, WA 98056
(206) 296-4700

C) WHITE CENTER PUBLIC HEALTH CENTER
10821 8th Ave., S.W.
Seattle, WA 98146
(206) 296-4646

D) EASTGATE PUBLIC HEALTH CENTER
14350 S.E. Eastgate Way
Bellevue, WA 98007
(206) 296-4920

E) DOWNTOWN PUBLIC HEALTH CENTER
2124 4th Ave.
Seattle, WA 98121
(206) 296-4755

F) AUBURN PUBLIC HEALTH CENTER
901 Auburn Way N.
Auburn, WA 98002
(206) 296-8400

SKAGIT COUNTY HEALTH DEPARTMENT
700 S 2nd St., Rm 301
Mount Vernon, WA 98273
(360) 336-9380

SNOHOMISH HEALTH DISTRICT
3020 Rucker Ave., Ste. 206
Everett, WA 98201
(425) 339-5251

SPOKANE COUNTY HEALTH DISTRICT
W. 1101 College Ave.
Spokane, WA 99201
(509) 324-1500

TACOMA-PIERCE COUNTY HEALTH DEPARTMENT
3629 South "D" St.
Tacoma, WA 98418
(253) 798-6410

THURSTON COUNTY HEALTH DEPARTMENT
529 Southwest Fourth
Olympia, WA 98501
(360) 786-5581

WALLA WALLA COUNTY-CITY HEALTH DEPARTMENT
314 W Main St.
P.O. Box 1753
Walla Walla, WA 99362
(509) 524-2650

WHATCOM COUNTY HEALTH DEPARTMENT
1500 N State St.
Bellingham, WA 98225
(360) 676-6724

WHITMAN COUNTY HEALTH DEPARTMENT
310 N. Main St.
Colfax, WA 99111
(509) 397-6280

YAKIMA COUNTY HEALTH DISTRICT
1210 Ahtanum Ridge Rd.
Union Gap, WA 98903
(509) 575-4040

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.

Important Notice Regarding Replacement of Insurance

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

(Save this notice! It may be important to you in the future.)

The decision to buy a new life insurance policy or annuity and discontinue or change an existing one is very important. Your decision could be a good one - or a mistake. It should be carefully considered. The Washington state insurance commissioner requires us to give you this notice to help you make a wise decision.

Statement to Applicant by Insurance Producer

I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following factors, which I call to your attention.

1. Can there be reduced benefits or increased premiums in later years?
   ☐ No ☐ Yes, explain: _____
2. Are there penalties, set up or surrender charges for the new policy?
   ☐ No ☐ Yes, explain emphasizing any extra cost for early withdrawal: _____
   _____
3. Will there be penalties or surrender charges under the existing insurance as a result of the proposed transaction?
   ☐ No ☐ Yes, explain: _____
4. Are there adverse tax consequences from the replacement under current tax law?
   ☐ No ☐ Yes, explain: _____
5. a) Are interest earnings a consideration in this replacement?
   ☐ No ☐ Yes
   b) If "Yes", explain what portions of premiums or contributions will produce limited or no earnings. As pertinent, include in your explanation the need for minimum deposits to enhance earnings, and the reduction of earnings that may result from set up charges, policy fees, and other factors.
   _____
   _____
   _____
6. Are minimum amounts required to be on deposit before excess interest will be paid?
   ☐ No ☐ Yes, explain: _____
7. If the new program is based on a variable or universal life insurance policy or a single-premium policy or annuity:
   a) Are the interest rates quoted ☐ before or ☐ after fees and mortality charges have been deducted?
   b) Interest rates are guaranteed for how long? _____
   c) The minimum interest rate to be paid is how much? _____
   d) If applicable, the rate you pay to borrow is _____ , and the limit on the amount that can be borrowed is _____
   e) The surrender charges are _____
   f) The death benefit is _____
8. Are there other short or long term effects from the replacement that might be materially adverse?
   ☐ No ☐ Yes, explain: _____

_____ _____
Signature of Insurance Producer Date

_____ _____
Name of Insurance Producer (print or type) Address

List of Policies or Contracts to be replaced

Company	Insured	Contract Number

CAUTION: The insurance commissioner suggests you consider these points:

- Usually, contestable and suicide periods start again under a new policy. Benefits might be excluded under a new policy that would be paid under existing insurance.
- Terminating or altering existing coverage before new insurance has been issued might leave you unable to purchase other life insurance or let you buy it only at substantially higher rates.
- You are entitled to advice from the existing insurance producer or company. Such advice might be helpful.
- Study the comments made above by the insurance producer. They apply to you and this proposal. They are important to you and your future.

Completed copy received:

Applicant's Signature _____ Date _____

Joint Applicant's Signature _____ Date _____

THIS COMPLETED FORM SHOULD BE FILED PERMANENTLY WITH YOUR NEW INSURANCE POLICY.

Policy Illustration Certification

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

Typically a "policy illustration" is provided to help you understand, in general terms, how a policy will work. A policy illustration shows policy premiums, death benefits, cash values and information about other items that can affect the performance of your policy. Because a policy illustration for the specific policy you are applying for was not provided, we ask that both you and your producer acknowledge:

1. Either no policy illustration was used when recommendations were made by my producer or the illustration provided was different than the policy applied for, or
2. A computer screen illustration for the policy applied for was displayed but not printed, and
3. I understand an illustration reflecting the actual policy issued as a result of this application will be provided at the time of policy delivery.

Owner *(print name)*

X
Signature of Owner

Date

Producer *(print name)*

Producer No. / Profile No.

X
Signature of Producer

Date

Proposed Insured *(if different than applicant) (print name)*

Instructions to Producer

Submit signed and dated form with the application to the Client Service Office.

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