# Application for Insurance

## Instructions and Checklist

**Ameritas Life Insurance Corp. of New York**
P.O. Box 81889, Lincoln, NE 68501 / 877-280-6110, Fax 402-467-7335

1. The Notice of Insurance Information Practices must be given to the client prior to completion of the application.
2. The proposed insured, spouse, and applicant, if any, must sign the form where indicated.
3. We will not accept applications on minors younger than fifteen (15) days old. A parent or guardian must give consent to any applicant under age 18.
4. 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 white out to change any answers, or fill in any blank information after the application has been signed.
5. Taxpayer Identification Number and Certification form must be completed and returned to the Home Office.
6. If a life insurance or annuity contract is being replaced, you must follow appropriate replacement procedures.
7. Advise all clients that qualify for the EZ App process that full underwriting is available.
8. All premium payments must be written to the issuing company. If multiple companies including Ameritas Life of NY are involved, one check may be written to Ameritas Life of NY. If multiple companies are involved without Ameritas Life of NY, then the check can be written to either of the companies.

☐ **TRADITIONAL & UNIVERSAL LIFE** ☐ **DISABILITY INCOME** ☐ **EZ APP**

| | | | | Included? | |
|---|---|---|---|---|---|
| **Application Kit** | Provide to Insured | UN 2550 NI NY | Notice of Insurance Practices | ☐ Yes | N/A |
| | Always Submit | UN 2550 PI NY | Personal Information for Ameritas Life of NY Policies | ☐ Yes | N/A |
| | | UN 2550 PI-A NY | Personal Information for VUL and DI policies | ☐ Yes | N/A |
| | | UN 2550 PD NY | Universal Life/Traditional Life / Term Policy Details | ☐ Yes | ☐ No |
| | Submit as Required | UN 2550 PI-B NY | Personal Information (only as necessary) for DI policies | ☐ Yes | ☐ No |
| | | UN 2550 FI NY | Life Financial Information | ☐ Yes | ☐ No |
| | | or<br>UN 2550 DI NY | Disability Income Policy Details | ☐ Yes | ☐ No |
| | | UN 2550 DI FI NY | Disability Income Occupation and Financial Details | ☐ Yes | ☐ No |
| | | UN 2550 LQ NY | Lifestyle Questionnaire | ☐ Yes | ☐ No |
| | | UN 2550 HQ NY | Health Questionnaire (for each proposed insured)* | ☐ Yes | ☐ No |
| | Always Submit | UN 2550 AU NY | Authorization | ☐ Yes | N/A |
| | | UN 2550 AG NY | Agreement | ☐ Yes | N/A |
| | | UN 2550 PS NY | Producer's Statement | ☐ Yes | N/A |
| | | UN 2550 CR NY | Conditional Receipt** | ☐ Yes | N/A |

* If the coverage requested is within the Company's nonmedical limits, no other application forms are required. If the coverage requested exceeds our published nonmedical limits, a medical or paramedical examination should be obtained. For teleunderwriting (EZ App), you are not responsible for obtaining an exam. 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.

** Conditional Receipt is given to the premium payor whenever full initial premium is collected. Do not accept premium if the amount of life insurance requested exceeds a death benefit of $1,000,000, or $8,000 per month of Disability Income or Disability Overhead Expense. Also, premium should not be accepted if the proposed insured is age 75 or older, or has been treated for heart disease, diabetes, stroke, or cancer within the past 12 months, or has been admitted to a medical facility within the past 90 days. Premium payments must be made by personal or business check only. No cash, money orders, traveler's checks or bank checks are permitted. All premium checks must be made payable to the appropriate Company.

Securities offered through affiliate Ameritas Investment Corp., member FINRA and SIPC.

# Application for Insurance

## Notice of Insurance Information Practices

**Ameritas Life Insurance Corp. of New York**
P.O. Box 40888, Cincinnati, OH 45240
877-280-6110, Fax 513-595-2352
(Client Service Office)

**The Union Central Life Insurance Company**
P.O. Box 40888, Cincinnati, OH 45240
800-319-6901, Fax 513-595-2352
(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 the Medical Information Bureau, 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 companies listed above ("the Companies") or their reinsurers may, however, make a brief report thereon to the Medical Information Bureau, Inc. (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 Companies or their 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 Companies may also use a Personal History Interview. A specially trained interviewer may call to discuss information contained in your application or to ask questions related to the underwriting of your insurance. We will attempt to conduct this telephone interview at your convenience and at a number you designate.

In the event of an adverse underwriting decision, upon written request, we will provide you with the specific reason in writing for that adverse underwriting decision.

As a general practice, we will not disclose personal information about you to anyone else without your consent, unless a legitimate business need exists or disclosure is required or permitted by law. A description of the circumstances under which information about you might be disclosed without your authorization will be sent to you upon request.

You have a right of access to personal information we maintain in our files and to request correction, amendment, or deletion of any information you believe to be incorrect. You may request a description of established procedures which will allow access to and correction of such personal information.

If you wish to have a more detailed explanation of our information practices, including your rights of access to and correction of personal information, please contact the Underwriting Department at the above address.

**DETACH AND DELIVER TO PROPOSED INSURED BEFORE COMPLETION OF THE APPLICATION**

# Application for Insurance

1010

## Personal Information

**Ameritas Life Insurance Corp. of New York**
P.O. Box 40888, Cincinnati, OH 45240 / 877-280-6110, Fax 513-595-2352 (Client Service Office)

**1. Proposed Insured (One):**

a) Name: _____

b) Date of Birth:_____ c) Sex: ☐ Male ☐ Female

d) Place of Birth: _____

e) Social Security/Tax ID No.: _____

f) Driver's License or other Government issued picture ID:

_____ State:_____

g) Home Address:_____

City: _____ State: _____ ZIP: _____

h) Years at this Address: _____

i) Tel. *(Home)*: _____

*(Business)*: _____

Fax: _____

E-mail: _____

Best time to call: _____ at: ☐ Business ☐ Home

In the event you are not available when our interviewer calls, may we speak with your spouse? ☐ Yes ☐ No

j) Residency Status: ☐ U.S. Resident ☐ Other:_____

k) Are you a U.S. Citizen: ☐ Yes ☐ No If "No," complete Foreign National form UN 0918 and provide the following:

Citizenship: _____

Visa Type: _____ Visa #:_____

l) Employer Name: _____

Address: _____

City: _____ State: _____ ZIP:_____

m) Occupation: _____ Years:_____

n) Duties: _____

**2. Owner Information (One):**

*(Complete only if Owner is other than Proposed Insured.)*

a) ☐ Individual b) ☐ Trust *(provide copy)* c) ☐ Partnership

d) ☐ Corporation: County of Incorporation: _____

e) Full Name: _____

f) Relationship to Proposed Insured(s): _____

g) Trustee(s) Name: _____

h) Date of Birth or Date of Trust: _____

i) Social Security/Tax ID No.: _____

j) Driver's License or other Government issued picture ID:

_____ State:_____

k) Address: _____

_____

City: _____ State: _____ ZIP: _____

l) Tel. *(Home)*: _____ *(Business)*: _____

Fax: _____ E-mail:_____

m) Residency Status: ☐ U.S. Resident ☐ Other: _____

n) Are you a U.S. Citizen: ☐ Yes ☐ No If "No," complete Foreign National form UN 0918 and provide the following:

Citizenship: _____

Visa Type:_____ Visa #: _____

o) Multiple Ownership *(indicate type)*:

☐ Joint with Survivorship

☐ Tenants in Common

p) Successor Owner:

Name: _____

Social Security/Tax ID No.: _____

**3. Beneficiary Information:** *(Subject to change by Owner.)*

a) Primary Beneficiary: _____

_____

Address:_____

City: _____ State:_____ ZIP:_____

Relationship to Proposed Insured: _____

Social Security/Tax ID: _____

Date of Birth or Date of Trust: _____

b) Contingent Beneficiary:_____

_____

Address:_____

City: _____ State:_____ ZIP:_____

Relationship to Proposed Insured: _____

Social Security/Tax ID: _____

Date of Birth or Date of Trust: _____

# Application for Insurance



## Personal Information (continued)

**Ameritas Life Insurance Corp. of New York**
P.O. Box 40888, Cincinnati, OH 45240 / 877-280-6110, Fax 513-595-2352 (Client Service Office)

**1. Proposed Insured (Two):**

a) Name: _____

b) Date of Birth:_____ c) Sex: ☐ Male ☐ Female

d) Place of Birth: _____

e) Social Security/Tax ID No.: _____

f) Driver's License or other Government issued picture ID:
_____ State:_____

g) Home Address:_____
City: _____ State: _____ ZIP: _____

h) Years at this Address: _____

i) Tel. *(Home)*: _____
*(Business)*: _____
Fax: _____
E-mail: _____
Best time to call: _____ at: ☐ Business ☐ Home
In the event you are not available when our interviewer calls, may we speak with your spouse? ☐ Yes ☐ No

j) Residency Status: ☐ U.S. Resident ☐ Other:_____

k) Are you a U.S. Citizen: ☐ Yes ☐ No If "No," complete Foreign National form UN 0918 and provide the following:
Citizenship: _____
Visa Type: _____ Visa #:_____

l) Employer Name: _____
Address: _____
City: _____ State: _____ ZIP:_____

m) Occupation: _____ Years:_____

n) Duties: _____

**2. Owner Information (Two):**
*(Complete only if Owner is other than Proposed Insured.)*

a) ☐ Individual b) ☐ Trust *(provide copy)* c) ☐ Partnership

d) ☐ Corporation: County of Incorporation: _____

e) Full Name: _____

f) Relationship to Proposed Insured(s): _____

g) Trustee(s) Name: _____

h) Date of Birth or Date of Trust: _____

i) Social Security/Tax ID No.: _____

j) Driver's License or other Government issued picture ID:
_____ State:_____

k) Address: _____
_____
City: _____ State: _____ ZIP: _____

l) Tel. *(Home)*: _____ *(Business)*: _____
Fax: _____ E-mail:_____

m) Residency Status: ☐ U.S. Resident ☐ Other: _____

n) Are you a U.S. Citizen: ☐ Yes ☐ No If "No," complete Foreign National form UN 0918 and provide the following:
Citizenship: _____
Visa Type:_____ Visa #: _____

o) Multiple Ownership *(indicate type)*:
☐ Joint with Survivorship
☐ Tenants in Common

p) Successor Owner:
Name: _____
Social Security/Tax ID No.: _____

**3. Proposed Insured: (Child One or Other.)**

a) Name: _____

b) Relationship: _____

c) Date of Birth:_____ d) Sex: ☐ Male ☐ Female

e) Place of Birth: _____

f) Social Security No: _____

g) Ins. in Force/Company: _____

h) Driver's License No.:_____

**4. Proposed Insured: (Child Two or Other.)**

a) Name: _____

b) Relationship: _____

c) Date of Birth:_____ d) Sex: ☐ Male ☐ Female

e) Place of Birth: _____

f) Social Security No: _____

g) Ins. in Force/Company: _____

h) Driver's License No.:_____

# Disability Income

## Policy Details

**Ameritas Life Insurance Corp. of New York**
P.O. Box 40888, Cincinnati, OH 45240 / 877-280-6110, Fax 513-595-2352 (Client Service Office)

## 1. Individual Disability Income Insurance:

a) Contract Type
- ☐ Noncancelable and Guaranteed Renewable (5501-NC)
- ☐ Guaranteed Renewable (5502-GR)

b) Definition of Disability
- ☐ Own Occ for benefit period (OO)
- ☐ Own Occ and Not Working for benefit period (NW)
- ☐ 60 month Own Occ and Not Working thereafter (ON)

c) Base Monthly Benefit: $ _____

d) Elimination Period *(Days)*:
☐ 30 ☐ 60 ☐ 90 ☐ 180 ☐ 365 ☐ 730

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

f) Riders:
- ☐ Enhanced Residual Disability Rider
- ☐ Basic Residual Disability Rider
- ☐ Cost of Living Adjustment Rider – 6% Compound
- ☐ Cost of Living Adjustment Rider – 3% Simple
- ☐ Social Insurance Substitute Rider:
  Amount: $_____ Elimination Period *(Days)*: _____
- ☐ Catastrophic Disability Rider:
  Amount: $_____ Elimination Period *(Days)*: _____
  Benefit Period *(Years)*: _____
- ☐ Future Increase Option Rider: Amount: $ _____
- ☐ Automatic Increase Rider
- ☐ Other: _____

g) Do you understand and agree that under the terms of the Individual Disability Income policy applied for, no monthly benefit is payable during the elimination period of any disability? ☐ Yes ☐ No

## 2. Business Overhead Expense (5503-BOE):

a) Maximum Monthly Benefit: $_____

b) Elimination Period *(Days)*:
☐ 30 ☐ 60 ☐ 90

c) Benefit Period *(Months)*:
☐ 12 ☐ 18 ☐ 24

d) Riders:
- ☐ Future Increase Option Rider: Amount: $ _____
- ☐ Substitute Salary Expense Rider: Amount: $_____

e) Do you understand and agree that under the terms of the Business Overhead Expense policy applied for, no monthly benefit is payable during the elimination period of any disability? ☐ Yes ☐ No

## 3. Premium:

a) Premium Payor:
☐ Insured ☐ Employer ☐ Other _____

b) Send Premium Notices to:
- ☐ Residence ☐ Business
- ☐ Other *(specific relationship and address)*

_____

_____

c) Premium Frequency:
- ☐ Annual
- ☐ Semi-Annual
- ☐ Quarterly
- ☐ Step Rate
- ☐ Electronic Funds Transfer *(complete EFT form)*
- ☐ Salary Allotment/List Bill
  List bill number _____
- ☐ Other: _____

d) Association Discount: ☐ Yes ☐ No *(If "Yes," give IPN.)*
Association IPN: _____

e) Has any premium been given in connection with this application? ☐ Yes ☐ No
*(If "Yes," state amount paid for which conditional receipt has been given, the terms of which are hereby agreed to.)*

Individual Disability Income: $_____

Business Overhead Expense: $_____

Total: $_____

## 4. Business Ownership:

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

b) If yes, what type of business is it?
☐ C-Corp ☐ S-Corp ☐ LLP
☐ LLC ☐ Partnership ☐ Sole Proprietor
☐ Other: _____

c) If yes, how many other owners or partners are there? _____

## 5. Occupation / Employment:

a) How many total employees are there in the business where you work? _____

b) How long have you been employed at the business where you work? _____

c) How many hours per week do you work in your primary occupation? _____

d) How long have you worked in your primary occupation? _____

e) Do you have any other occupations not listed elsewhere on this application? ☐ Yes ☐ No
*(If "Yes," give details, including description of duties and hours worked per week.)*

_____

_____

f) If this application is for Individual Disability Income Insurance, will your employer pay the premium for this coverage? ☐ Yes ☐ No

g) If yes, what percent will be paid by the employer? _____%

h) If yes, will the premium paid by the employer be included in your taxable income? ☐ Yes ☐ No

i) Have you ever had a professional license suspended or revoked; or is such license under review; or have you been disbarred? ☐ Yes ☐ No
*(If "Yes," give details.)*

_____

_____

# Disability Income

## Occupation and Financial Details

**Ameritas Life Insurance Corp. of New York**
P.O. Box 40888, Cincinnati, OH 45240 / 877-280-6110, Fax 513-595-2352 (Client Service Office)

## 1. Financial Information:

a) Annual Earned Income for Federal income tax purposes: *(Fill in each applicable section.)*

| | Current Tax Year *(Annualized)* | Last Tax Year | Two Tax Years Ago |
|---|---|---|---|
| Salary/ W-2 wages: | $ | $ | $ |
| Sole Proprietor *(Schedule C)*: | $ | $ | $ |
| Partnership *(Schedule E)*: | $ | $ | $ |
| S-Corp *(Schedule E)*: | $ | $ | $ |
| LLC or LLP *(Schedule E)*: | $ | $ | $ |
| C-Corp *(Form 1120)*: | $ | $ | $ |

b) Annual Unearned Income for Federal income tax purposes, if greater than $20,000 *(rental income, interest, dividends, etc.)*: $

c) Do you receive a pension or profit sharing contribution from the business where you work? ☐ Yes ☐ No

d) If "Yes," what is the annual contribution? $

e) Net Worth: *(If net worth exceeds $4,000,000, itemize below.)*

Cash, savings, stocks, bonds: $

Personal residence: $

Other real estate: $

Business interest: $

Personal Property: $

Other *(describe)*: $

f) Have you ever filed for personal or business bankruptcy; or had any lawsuits, judgments, or liens against you? ☐ Yes ☐ No *(If "Yes," give details. Include: dates, amounts, location, and status.)*

_____

_____

## 2. Insurance Details:

a) Do you have any group or individual disability insurance in force, or for which you will become eligible in the next year, or applications currently pending? ☐ Yes ☐ No

b) If "Yes," list coverage details in the following table. *(For type of coverage, indicate as: group, individual, association, overhead expense, key person, buy-out, etc.)*

| | Policy 1 | Policy 2 |
|---|---|---|
| Company: | | |
| Type of Coverage: | | |
| Total Monthly Benefit: | | |
| Issue Date: | | |
| Paid to Date: | | |
| Social Security Benefit: | | |
| Automatic Increase Option: | | |
| Future Increase Option: | | |
| Employer Paid: | | |

## 3. Existing Insurance *(replacement):*

Will any disability insurance with Ameritas Life of NY or any other insurance company be replaced, reduced or changed if the insurance now applied for is issued? ☐ Yes ☐ No

(If "Yes," give details.)

Company: _____

Policy Number: _____

Amount to be replaced: $ _____

Other changes: _____

## 4. Insurance Producer's Replacement Statement:

To the best of your knowledge, does the policy applied for involve replacement, in whole or in part, of any existing life insurance, annuity, disability income or overhead expense insurance, or any other accident and sickness insurance? ☐ Yes ☐ No

(If "Yes," give details.)

Company: _____ Policy No.: _____

## 5. If applying for Business Overhead Expense Insurance, complete the following:

a) Not including you, what is the number of employees and partners in your profession in the business where you work?

Employees: _____ Partners: _____

b) For what percent of the total monthly overhead expenses are you responsible? _____ %

c) List that portion of monthly overhead expenses for which you are responsible: *(Exclude: payments or salaries paid to you, partners or employees in your profession.)*

Rent/Lease: $

Utilities: $

Telephone: $

Depreciation: $

Liability Insurance: $

Property Taxes: $

Salaries: $

Mortgage Interest: $

Payroll Taxes: $

Employee Benefits: $

Other: $

d) Salaries of partners or employees in your profession: $

e) If you are reimbursed in any manner for any of the above expenses, provide complete details:

_____

_____

_____

_____

# Application for Insurance

## Lifestyle Questionnaire

**Ameritas Life Insurance Corp. of New York**
P.O. Box 40888, Cincinnati, OH 45240
877-280-6110, Fax 513-595-2352
(Client Service Office)

**The Union Central Life Insurance Company**
P.O. Box 40888, Cincinnati, OH 45240
800-319-6901, Fax 513-595-2352
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### Lifestyle Questions:

*(Please provide details for "Yes" answers. )*

Has any person proposed for coverage:

1. Used tobacco or nicotine products in any form within the last five years? *(In Details, provide dates and type: cigarettes, cigars, cigarillos, a pipe, chewing tobacco, nicotine patches, gum, etc.)* ☐ Yes ☐ No
2. 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
3. Ever received or claimed: indemnity, benefits, or a payment for any injury, sickness or impaired condition? ☐ Yes ☐ No
4. In the past three years, ever made any flights as: a pilot, student pilot, or crew member of any aircraft or intend to do so? *(If "Yes," complete Aviation Questionnaire.)* ☐ Yes ☐ No
5. Been convicted of a moving traffic violation, had any traffic accidents, or had a driver's license revoked or suspended within the past five years? ☐ Yes ☐ No
6. Been convicted of, or currently awaiting trial on the violation of any criminal law? ☐ Yes ☐ No
7. In the next year, any intention of traveling outside the U.S. or Canada or residing outside of the U.S.? *(If "Yes," complete Foreign Travel Questionnaire.)* ☐ Yes ☐ No
8. Belong to or intend joining: any active or reserve military, naval, or aeronautic organization? *(If "Yes," complete Military Service Questionnaire.)* ☐ Yes ☐ No
9. Engaged in or plan to engage in any form of the following: *(If "Yes," check all boxes below that apply and complete appropriate form(s).)* ☐ Yes ☐ No

   ☐ Motorized racing
   ☐ Parachuting/Skydiving
   ☐ Ballooning
   ☐ Rodeo
   ☐ Snowmobiling
   ☐ Boat racing
   ☐ Scuba diving
   ☐ Hang-gliding
   ☐ Mountain climbing
   ☐ Competitive skiing
   ☐ Gliding
   ☐ Other: _____

**Proposed Insured One** - Details for any "Yes" answers to Lifestyle Questions: *(Indicate question number and timeframe.)*

**Proposed Insured Two** - Details for any "Yes" answers to Lifestyle Questions: *(Indicate question number and timeframe.)*

# Application for Insurance

## Health Questionnaire

**Ameritas Life Insurance Corp. of New York**
P.O. Box 40888, Cincinnati, OH 45240
877-280-6110, Fax 513-595-2352
(Client Service Office)

**The Union Central Life Insurance Company**
P.O. Box 40888, Cincinnati, OH 45240
800-319-6901, Fax 513-595-2352
(Client Service Office)

Name of Proposed Insured: _____

**Health Questions. Please provide Details for "Yes" answers.**

1. a) Height: _____ b) Weight: _____
   c) Have you lost 10 lbs. or more in the past 12 months? ☐ Yes ☐ No
   d) Have you gained 10 lbs. or more in the past 12 months? ☐ Yes ☐ No
2. To the best of your knowledge and belief, have you ever been medically treated for or had any known indication of:
   a) Disorder of eyes, ears, nose, or throat? ☐ Yes ☐ No
   b) Dizziness, vertigo, fainting, seizures, recurrent headache; speech defect, paralysis, or stroke? ☐ Yes ☐ No
   c) Shortness of breath, bronchitis, pleurisy, asthma, emphysema, tuberculosis or chronic respiratory disorder? ☐ Yes ☐ No
   d) Chest pain, palpitation, high blood pressure, heart murmur, heart attack or other disorder of the heart or blood vessels? ☐ Yes ☐ No
   e) Jaundice, intestinal bleeding; ulcer, hernia, colitis, hepatitis, diverticulitis, recurrent indigestion or other disorder of the stomach, intestines, liver or gallbladder? ☐ Yes ☐ No
   f) Sugar, albumin, blood or pus in urine; sexually transmitted disease; stone or other disorder of kidney or bladder? ☐ Yes ☐ No
   g) Diabetes, thyroid, or other endocrine disorders? ☐ Yes ☐ No
   h) Disorder of the breasts, reproductive organs, or prostate? ☐ Yes ☐ No
   i) Neuritis, arthritis, rheumatism, gout, or disorder of or injury to the bones, muscles, nerves, knees, wrists or other joints? ☐ Yes ☐ No
   j) Disorder of the skin, lymph glands, cyst, tumor or cancer? ☐ Yes ☐ No
   k) Allergies; anemia or other disorder of the blood, excluding AIDS, or HIV? ☐ Yes ☐ No
   l) Spinal, neck or back disorder or injury, including sprains, strains, or disc disorder? ☐ Yes ☐ No
   m) Anxiety, depression, stress, or other mental, nervous, psychiatric or emotional disorder? ☐ Yes ☐ No
   n) Chronic fatigue, fibromyalgia, or Epstein-Barr virus? ☐ Yes ☐ No
   o) C-section, miscarriage, or complication of pregnancy? ☐ Yes ☐ No
   p) Any mental or physical disorder not listed above? ☐ Yes ☐ No
3. Have you ever consulted a chiropractor? ☐ Yes ☐ No
4. Are you currently pregnant? ☐ Yes ☐ No
5. Other than noted above, have you within the past five years:
   a) Had a checkup, consultation, illness, injury, or surgery; been a patient in a hospital, clinic, sanatorium, or other medical facility; had an electrocardiogram, X-ray, or other diagnostic test? ☐ Yes ☐ No
   b) Been advised by a licensed medical professional to have any diagnostic test, other than an HIV test, hospitalization, or surgery which was not completed? ☐ Yes ☐ No
6. Within the past ten years, have you ever:
   a) Used marijuana, cocaine, barbiturates, tranquilizers, heroin, LSD, amphetamines, morphine, narcotics; or any other drug, except as legally prescribed by a physician? ☐ Yes ☐ No
   b) Sought or received medical treatment or professional advice for the use of alcohol, cocaine, marijuana, narcotics or any other drug? ☐ Yes ☐ No
   c) Consumed alcoholic beverages? If yes, specify extent. ☐ Yes ☐ No
7. Have you been diagnosed by a licensed medical professional as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? ☐ Yes ☐ No
8. Have any of your immediate family members (parents, brothers and sisters), died of or been diagnosed as having; coronary artery disease, diabetes, cancer, stroke or kidney disease, prior to age 60? ☐ Yes ☐ No

| | Age if Living | Cause of Death | Age at Death |
|---|---|---|---|
| Father | _____ | _____ | _____ |
| Mother | _____ | _____ | _____ |
| Brothers & Sisters | _____ | _____ | _____ |

9. a) Name and address of personal or attending doctor:
   _____
   _____
   _____
   b) Telephone: _____
   c) Date last consulted: _____
   Reason and any medication/treatment given: _____
   _____
   _____
   d) List any medications *(prescription or nonprescription)* you are taking currently:
   _____
   _____

For each "Yes" answer, give details. *(Identify: question number, diagnoses, dates, duration, names and addresses of all attending physicians and medical facilities. Attach additional Health Questionnaire page, UN 2550 HQ NY, or additional sheet of paper, if needed.)*

# Application for Insurance

## Agreement

☐ **Ameritas Life Insurance Corp. of New York**
P.O. Box 40888, Cincinnati, OH 45240
877-280-6110, Fax 513-595-2352
(Client Service Office)

☐ **The Union Central Life Insurance Company**
P.O. Box 40888, Cincinnati, OH 45240
800-319-6901, Fax 513-595-2352
(Client Service Office)

## Agreement

The undersigned represent that their statements in this application and Part II, if such Part II is required by the companies listed above ("the Companies"), 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 CONDITIONAL RECEIPT;

**(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 any of the Companies' rights or requirements;

(e) this application was signed and dated in the state indicated; and

(f) this application is to be attached to and made a part of the policy.

If applying for an indeterminate premium plan:

(a) the premium for such plan is guaranteed for the initial guarantee period, and after such period, the current annual premium is not guaranteed and may change; and

(b) the premium will never exceed the specified maximum.

## Fraud Notice

The following Fraud Warning Notice applies to Disability Income insurance only: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Dated at: _____
City State Month Day Year

_____
Print or Type Proposed Insured Name

X _____
Signature of Proposed Insured

_____
Print or Type Name of Other Proposed Insured

X _____
Signature of Other Proposed Insured

_____
Print or Type Owner if not Proposed Insured

X _____
Signature of Owner if not Proposed Insured

_____
Print or Type name of Personal Representative of Proposed Insured

X _____
Signature of Personal Representative of Proposed Insured

_____
Description of Authority of Personal Representative
(Parent, Legal Guardian, Attorney-in-Fact)
(Attach documentation in support of your authority)

_____ _____
Print or Type Insurance Producer Name Producer No./Sit. Code

X _____ _____
Signature of Licensed Soliciting Producer Producer State Lic. No.

_____ _____
Print or Type Insurance Producer Name Producer No./Sit. Code

X _____ _____
Signature of Licensed Soliciting Producer Producer State Lic. No.

_____ _____
Agency Name Agency No.

## Taxpayer Identification Number (TIN)

Under penalties of perjury, I certify that:
1) The number shown on this form is my correct TIN (or I am waiting for a number to be issued to me); and
2) I am not subject to backup withholding either because: (a) I am exempt from backup withholding; (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends; or (c) the IRS has notified me that I am no longer subject to backup withholding.
3) I am a U.S. Citizen or other U.S. Person (including a U.S. resident alien).

| Social Security Number | Employer Identification Number |
|---|---|
| | |

Cross out item (2) if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return.

X _____ _____
Signature of Owner, Trustee/Employer Date

# Application for Insurance

## Authorization

☐ **Ameritas Life Insurance Corp. of New York**
P.O. Box 40888, Cincinnati, OH 45240
877-280-6110, Fax 513-595-2352
(Client Service Office)

☐ **The Union Central Life Insurance Company**
P.O. Box 40888, Cincinnati, OH 45240
800-319-6901, Fax 513-595-2352
(Client Service Office)

### Authorization to Obtain and Disclose Information

I authorize any health care providers, pharmacy benefit manager, hospitals, insurers, the Medical Information Bureau, Inc. ("MIB"), 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, the use of drugs, alcohol (except for substance abuse treatment program records and psychotherapy notes for which special authorization is required), or tobacco, HIV, AIDS and sexually transmitted diseases, prescription drug records, 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 companies listed above ("the Companies"), their reinsurers, or any other agent or agency acting on the Companies' behalf.

I authorize the Companies, or their reinsurers, to disclose data or facts obtained, including Protected Health Information, to the MIB. Data or facts obtained will be released only: (1) to reinsurers; (2) to MIB; (3) to persons performing business duties as directed or contracted for by the Companies related to the proposed insured's application or claim or other insurance-related functions; (4) as permitted or required by law; (5) to government officials when necessary to prevent or prosecute fraud or other illegal acts; and (6) to any person or entity having an authorization expressly permitting the disclosure. I acknowledge and agree that the personal data or facts used or disclosed under this authorization may be subject to redisclosure and no longer protected by federal privacy regulations.

I acknowledge and authorize 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 material misrepresented information on the application identified above which may arise during the processing or review of the application, or any other application for insurance; (4) administer coverage and claims; and (5) complete a consumer report, investigative consumer report or telephone interview about the proposed insured or claimant.

I agree that this authorization is valid for two years from the date shown below. I also agree that a copy is as valid as the original. I, or my authorized representative, am entitled to a copy. I understand that: (1) I can revoke this authorization at any time by giving written request to the Companies; (2) revoking this authorization will not affect any prior action taken by the Companies in reliance upon this authorization; and (3) failing to sign, or revoking this authorization may impair the Companies' ability to process my application or evaluate my claim and may be a basis for denying this application or a claim for benefits.

This application is to be attached to and made a part of the policy.

I acknowledge receipt of Notice of Insurance Information Practices.

Dated at: _____
City State Month Day Year

_____
Print or Type Name of Proposed Insured

**X** _____
Signature of Proposed Insured

_____
Print or Type Name of Other Proposed Insured
(If other than policyowner and age 14 1/2 or over.)

**X** _____
Signature of Other Proposed Insured
(If other than policyowner and age 14 1/2 or over.)

_____
Print or Type Name of Personal Representative of Proposed Insured

**X** _____
Signature of Personal Representative of Proposed Insured

_____
Description of Authority of Personal Representative
*(Parent, Legal Guardian, Attorney-in-Fact)*
*(Attach documentation in support of your authority.)*

# Application for Insurance

## Producer's Statement

**Ameritas Life Insurance Corp. of New York**
P.O. Box 40888, Cincinnati, OH 45240
877-280-6110, Fax 513-595-2352
(Client Service Office)

**The Union Central Life Insurance Company**
P.O. Box 40888, Cincinnati, OH 45240
800-319-6901, Fax 513-595-2352
(Client Service Office)

### 1. Background Information

a) How well acquainted are you with the purchaser?
☐ First Contact ☐ Well Known
☐ Casually ☐ Self
☐ Relative (relationship):_____

b) Initial contact with purchaser?
☐ Friend/Relative ☐ Direct-Mail Lead
☐ Referred Lead ☐ Home-Office Lead
☐ Cold Call
☐ Other: _____

c) Marital Status:
☐ Single ☐ Married
☐ Divorced ☐ Widowed

### 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:

_____

Estimate parents' worth: _____

Estimate parents' income: _____

c) Are all of proposed insured's minor brothers and sisters insured for an equal amount? ☐ Yes ☐ No

**Purpose of Insurance:**

d) Personal Life Insurance
☐ Survivor Needs ☐ Mortgage Acceleration
☐ Spouse Insurance ☐ Income Replacement
☐ Education Funding ☐ Retirement Funding
☐ Other *(specify):* _____

e) Business
☐ Key Person ☐ Deferred Compensation
☐ Business Purchase ☐ Executive Bonus (Sec. 162)
☐ Cover Debt ☐ Split Dollar
☐ Other *(specify):* _____

f) Estate
☐ Charitable Gifts ☐ Fund Trusts for Heirs
☐ Estate Tax ☐ Equalization between Heirs
☐ Other *(specify):* _____

### 5. Request for Additional or Alternate Life Policy(ies)

☐ Alternate Policy
☐ Additional Policy
(If requested, provide details):

_____

### 6. Disability Income Insurance Information

a) DI Occupational Class Quoted:
☐ 6A ☐ 5A ☐ 4A ☐ 3A ☐ 2A ☐ A ☐ B
☐ 6M ☐ 5M ☐ 4M ☐ 3M ☐ 2M ☐ M

b) BOE Occupation Class Quoted:
☐ B6 ☐ B5 ☐ B4

Producer Remarks:

_____

_____

### 7. 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.
- A current prospectus(es) was (were) delivered to the proposed insured. (Applicable to Variable Products Only.)
- All of the sales materials used have been approved in advance by the Home Office.
- I am familiar with the Guide to Market Conduct (form ULC 16), and the sale of this product is consistent with those guidelines.
- I have verified the accuracy of the proposed insured's and/or owner's identity.
- I certify that I have truly and accurately recorded on the application all the information supplied by the applicant.
- This application was in fact signed and dated in the state indicated.

**X** _____
Signature of Insurance Producer

_____
Print Full Name of Insurance Producer

Insurance Producer Number: _____

Agency Number: _____

# Application for Insurance

## Conditional Receipt

**Ameritas Life Insurance Corp. of New York**
P.O. Box 40888, Cincinnati, OH 45240 / 877-280-6110, Fax 513-595-2352 (Client Service Office)

**NOTICE TO PRODUCER AND APPLICANT -**

**Premium should not be accepted for Life Insurance if the amount applied for is over $1,000,000 or the proposed insured:** (1) is age 75 or older; or (2) has been treated for heart disease, diabetes, stroke, or cancer, within the past 12 months; or (3) has been admitted to a medical facility within the past 90 days.

**Premium should not be accepted for Disability Income or Business Overhead Expense if the monthly benefit applied for is over $8,000 or the proposed insured:** (1) is age 61 or older; or (2) has ever been treated for heart disease, diabetes, stroke, or cancer; or (3) has been admitted to a medical facility within the past 90 days.

**NOTICE TO APPLICANT -**
**PLEASE READ THIS RECEIPT CAREFULLY.**

**Terms and Conditions**
All of the terms and conditions of this receipt must be fulfilled for insurance to be in effect on the "coverage date," subject to the maximum amount limitations listed below, or no insurance will be in effect until delivery of the policy. The "coverage date" is the date of this application or Part II of this application or medical examination or other tests initially required by published rules of Ameritas Life Insurance Corp. of New York ("the Company") used when considering the benefits applied for, whichever date is latest. If a policy is issued under this receipt and application as of the "coverage date," the maximum amount limitation of this receipt will apply until the policy/policies is/are delivered. If the application is declined, the premium paid will be returned.

1. **Premium Payment**
   For Adjustable Life insurance, the premium payment taken with this application must be equal to or greater than the full initial premium. For any other life insurance, or Disability Income insurance, the premium taken with this application must be equal to the full first premium for the mode of premium and the applied for benefits. All premium checks must be made payable to the Company. Do not make checks payable to the insurance producer or present a blank check.

2. **Insurability**
   As of the "coverage date," the Company's Underwriting Officer must find each person proposed for insurance to be an acceptable risk at standard premium rates for the benefits applied for without an exclusion or restrictive endorsement.

3. a) **Maximum Amount** (applicable to life insurance only)
   Any liability of the Company under this and any other receipts may not exceed the lesser of: (a) the amount applied for in this application, or in the case of Adjustable Life insurance, the initial specified amount applied for; or (b) $1,000,000 of insurance and $100,000 of accidental death benefits.

   b) **Maximum Amount** (applicable to Disability Income or Business Overhead Expense only)

   Maximum benefits payable under this and any other receipts will be the lesser of: (a) the amount of monthly benefits applied for in this application; (b) the amount of monthly benefits that would be offered subject to our Underwriting Guidelines then in effect; or (c) $8,000 per month of Disability Income, Social Insurance Substitute and Catastrophic Disability benefits combined; or $8,000 per month of Business Overhead Expense and Substitute Salary Expense benefits combined.

4. **Limitations**
   a) **The Company's Liability:** Except as limited by this receipt, the Company's liability is governed by the terms of the policy(ies) applied for.
   b) **Suicide:** If any person proposed for insurance commits suicide, the Company's liability under this receipt will be limited to a refund of the premium payment submitted with the application.
   c) **Representation:** No knowledge of any fact on the part of any producer, broker, licensed representative, medical examiner, telephone interviewer, or other person shall be considered knowledge of the Company unless such fact is stated in the application.
   d) **Survivorship:** For Survivorship life insurance, no death benefit will be paid under this receipt unless both persons proposed for insurance have died.

No insurance is provided under this Conditional Receipt unless all terms and conditions of this receipt are met. This receipt is void if the payment is made by a check or draft that is not honored when presented for payment. This receipt is also void if there are any modifications made to the conditions of this receipt.

I have read, understand, and agree to all of the Terms and Conditions of this receipt and acknowledge receiving a copy of this receipt.

X _____
Signature of Applicant

RECEIVED from _____
this _____ day of _____ , in the year of _____ , by personal or business check, or Electronic Fund Transfer (EFT) authorization, the sum of $_____ in connection with this application for insurance, which application bears the same date as this receipt.

X _____
Signature of Producer

# Application for Insurance

## Conditional Receipt

**Ameritas Life Insurance Corp. of New York**
P.O. Box 40888, Cincinnati, OH 45240 / 877-280-6110, Fax 513-595-2352 (Client Service Office)

**NOTICE TO PRODUCER AND APPLICANT -**

**Premium should not be accepted for Life Insurance if the amount applied for is over $1,000,000 or the proposed insured:** (1) is age 75 or older; or (2) has been treated for heart disease, diabetes, stroke, or cancer, within the past 12 months; or (3) has been admitted to a medical facility within the past 90 days.

**Premium should not be accepted for Disability Income or Business Overhead Expense if the monthly benefit applied for is over $8,000 or the proposed insured:** (1) is age 61 or older; or (2) has ever been treated for heart disease, diabetes, stroke, or cancer; or (3) has been admitted to a medical facility within the past 90 days.

**NOTICE TO APPLICANT -**
**PLEASE READ THIS RECEIPT CAREFULLY.**

**Terms and Conditions**
All of the terms and conditions of this receipt must be fulfilled for insurance to be in effect on the "coverage date," subject to the maximum amount limitations listed below, or no insurance will be in effect until delivery of the policy. The "coverage date" is the date of this application or Part II of this application or medical examination or other tests initially required by published rules of Ameritas Life Insurance Corp. of New York ("the Company") used when considering the benefits applied for, whichever date is latest. If a policy is issued under this receipt and application as of the "coverage date," the maximum amount limitation of this receipt will apply until the policy/policies is/are delivered. If the application is declined, the premium paid will be returned.

1. **Premium Payment**
   For Adjustable Life insurance, the premium payment taken with this application must be equal to or greater than the full initial premium. For any other life insurance, or Disability Income insurance, the premium taken with this application must be equal to the full first premium for the mode of premium and the applied for benefits. All premium checks must be made payable to the Company. Do not make checks payable to the insurance producer or present a blank check.

2. **Insurability**
   As of the "coverage date," the Company's Underwriting Officer must find each person proposed for insurance to be an acceptable risk at standard premium rates for the benefits applied for without an exclusion or restrictive endorsement.

3. a) **Maximum Amount** (applicable to life insurance only)
   Any liability of the Company under this and any other receipts may not exceed the lesser of: (a) the amount applied for in this application, or in the case of Adjustable Life insurance, the initial specified amount applied for; or (b) $1,000,000 of insurance and $100,000 of accidental death benefits.

   b) **Maximum Amount** (applicable to Disability Income or Business Overhead Expense only)

   Maximum benefits payable under this and any other receipts will be the lesser of: (a) the amount of monthly benefits applied for in this application; (b) the amount of monthly benefits that would be offered subject to our Underwriting Guidelines then in effect; or (c) $8,000 per month of Disability Income, Social Insurance Substitute and Catastrophic Disability benefits combined; or $8,000 per month of Business Overhead Expense and Substitute Salary Expense benefits combined.

4. **Limitations**
   a) **The Company's Liability:** Except as limited by this receipt, the Company's liability is governed by the terms of the policy(ies) applied for.
   b) **Suicide:** If any person proposed for insurance commits suicide, the Company's liability under this receipt will be limited to a refund of the premium payment submitted with the application.
   c) **Representation:** No knowledge of any fact on the part of any producer, broker, licensed representative, medical examiner, telephone interviewer, or other person shall be considered knowledge of the Company unless such fact is stated in the application.
   d) **Survivorship:** For Survivorship life insurance, no death benefit will be paid under this receipt unless both persons proposed for insurance have died.

No insurance is provided under this Conditional Receipt unless all terms and conditions of this receipt are met. This receipt is void if the payment is made by a check or draft that is not honored when presented for payment. This receipt is also void if there are any modifications made to the conditions of this receipt.

I have read, understand, and agree to all of the Terms and Conditions of this receipt and acknowledge receiving a copy of this receipt.

X _____
Signature of Applicant

RECEIVED from _____
this _____ day of _____ , in the year of _____ , by personal or business check, or Electronic Fund Transfer (EFT) authorization, the sum of $_____ in connection with this application for insurance, which application bears the same date as this receipt.

X _____
Signature of Producer

# Why Sign a Second Authorization?

## Value-Added Underwriting

Ameritas
*fulfilling life.*

You reviewed and signed an additional Authorization Form allowing our Company's underwriting department to release medical information and other non-public information to Risk Insurance and Reinsurance Solutions (RIRS) and Fidelity Security Life Insurance Company (FSL) for the purpose of determining if a conditional disability insurance offer can be made by RIRS, on behalf of the issuing company, FSL.

The purpose of this form is to ensure you are aware of this action and that you are under no compulsion to consider this potential offer. Every effort will be made to offer a policy with our company, and the above option will only be used if and when our company is declining to make a disability offer based on our underwriting standards.

If, upon RIRS review, they decide to make a conditional offer, they will provide to your agent the information and he or she will contact you to discuss your options.

If you have any questions, please ask your agent and he or she can provide you further information. If you do not desire for your underwriting information to be provided for this review by RIRS, please let your agent know.

# Authorization to Release Nonpublic Personal Health Information To an Unrelated Insurer

Ameritas
fulfilling life

The purpose of this Authorization is to direct and authorize Ameritas Life Insurance Corp. and affiliates, including Ameritas Life Insurance Corp. of New York (collectively, "the Companies") to forward all of the nonpublic personal information that is, or has been collected on behalf of the undersigned in connection with an application for insurance with the Companies, to Fidelity Security Life Insurance Company (FSL), an unaffiliated insurer, or Presidential Life Insurance Company ("PL"), an unaffiliated insurer, or Risk Insurance and Reinsurance Solutions, Inc (RIRS), FSL's and PL's third party underwriter, in order for an insurance policy to be underwritten by FSL or PL, in the event that an insurance policy with the Companies is declined.

## (1) Applicant Information (please type or print)

| Last Name: | First Name: | | M.I.: |
|---|---|---|---|
| Street Address: | City: | State: | ZIP.: |
| Date of Birth: | Social Security No. | | |

## (2) IMPORTANT – Your signature below means that you understand and agree to the following:

- I understand that this Authorization is voluntary.
- I understand that the nonpublic personal information that will be disclosed pursuant to this authorization will contain all of the information that the Companies collect, or have collected about me in connection with my application to the Companies for insurance, without limitation, including personally identifiable information such as my name, address, telephone number(s), social security number and date of birth, in addition to medical records, hospital records, clinical records, psychiatric and psychological records, pharmaceutical records, and other records relating to any medical, psychological, psychiatric and/or therapeutic treatment that I may have received at any time. I am aware that the information I am authorizing to be disclosed may contain health information about me that is highly confidential including, but not limited to, testing or treatment related to alcohol or drug abuse; psychiatric or mental conditions; HIV or sexually transmitted disease; genetic disorders; and/or Sickle Cell anemia.
- I understand that the information to be disclosed is protected by law and that the same information may be re-disclosed by the recipient and may no longer be protected by the same law(s) that applied in the first instance.
- I understand that I may revoke this Authorization at any time during its effective period, except to the extent that action has been taken in reliance on this authorization, by requesting such in writing to: Ameritas, Attn. Privacy Office, P.O. Box 81889, Lincoln, NE 68510-1889.
- I understand that without this completed form with my signature, my request to release the information described above to a third party will not be honored.

## (3) Expiration:

This Authorization is effective for the disclosure of the information identified above only once to FSL or PL or RIRS and will expire after the disclosure has been made by the Companies.

I, the undersigned, hereby authorize the Companies to disclose the nonpublic personal information about me identified in Paragraph (2) above, to FSL or PL or RIRS. I acknowledge and understand that the Companies are relying on this Authorization to release the information outlined above and I agree to hold harmless the Companies, their employees, officers, directors, and their successors and assigns against any claims, losses, cost or damages which may arise in connection with the release of this information.

| Applicant Signature: | Date: |
|---|---|

# HIV Antibody Test



**Ameritas Life Insurance Corp. ("Company")** P.O. Box 81889, Lincoln, NE 68501 / 877-280-6110, Fax 402-467-7335

## Information Form for Insurance Applicant

### AIDS

Acquired Immunodeficiency Syndrome (AIDS) is a life-threatening disorder of the immune system, caused by a virus, HIV. The virus is transmitted by sexual contact with an infected person, from an infected mother to her newborn infant, or by exposure to infected blood (as in needle sharing during IV drug use). Persons at high risk of contracting AIDS include males who have had sexual contact with another man, intravenous drug users, hemophiliacs, and sexual contacts with any of these persons. AIDS does not typically develop until a person has been infected with HIV for several years. A person may remain free of symptoms for years after becoming infected. Infected persons have a 25% to 50% chance of developing AIDS over the next 10 years.

### The HIV Antibody Test

Before consenting to testing, please read the following important information:

1. **Purpose.** This test is being run to determine whether you may have been infected with HIV. If you are infected, you are probably not insurable. This test is not a test for AIDS; AIDS can only be diagnosed by medical evaluation.
2. **Positive Test Results.** If you test positive, you should seek medical follow-up with your personal physician. If your test is positive, you may be infected with HIV, may develop AIDS, and may wish to consider further independent testing.
3. **Accuracy.** An HIV test will be considered positive only after confirmation by a laboratory procedure that the state health officer has determined to be highly accurate. Nonetheless, the HIV antibody test is not 100% accurate. Possible errors include:
   a. **False positives:** The test gives a positive result, even though you are not infected. This happens only rarely and is more common in persons who have not engaged in high risk behavior. Retesting should be done to help confirm the validity of a positive test.
   b. **False negatives:** The test gives a negative result, even though you are infected with HIV. This happens most commonly in recently infected persons; it takes at least 4-12 weeks for a positive test result to develop after a person is infected.
4. **Side Effects.** A positive test result may cause you significant anxiety. A positive test may result in uninsurability for life, health, or disability insurance policies you may apply for in the future. Although prohibited by law, discrimination in housing, employment, or public accommodations may result if your test results were to become known to others. A negative result may create a false sense of security.
5. **Disclosure of Results.** A positive test result will be disclosed to you. You may choose to have information about your HIV test results communicated to you through your physician or through the alternative testing site.
6. **Confidentiality.** Like all medical information, HIV test results are confidential. An insurer, insurance agent, or insurance-support organization is required to maintain the confidentiality of HIV test results. However, certain disclosures of your test results may occur, including those authorized by consent forms that you may have signed as part of your overall application. Your test results may be provided to MIB, Inc. ("MIB"), a national insurance data bank. Your insurance agent will provide you with additional written information about this subject at your request.
7. **Prevention.** Persons who have a history of high risk behavior should change these behaviors to prevent getting or giving AIDS, regardless of whether they are tested. Specific important changes in behavior include safe sex practices (including condom use for sexual contact with someone other than a long-term monogamous partner) and not sharing needles. There is treatment for HIV that can help you stay healthy.
8. **Information.** For additional information about HIV and AIDS, the meaning of HIV test results, and the availability and location of HIV counseling services, you may call the New York AIDS Hotline at 1-800-541-AIDS.

Name of Physician or other person/entity_____

## Informed Consent

I hereby authorize the Company and its designated medical facilities to draw samples of my body fluids for the purpose of laboratory testing to provide applicable medical information concerning my insurability. These tests may include but are not limited to tests for: cholesterol and related blood lipids; diabetes; liver or kidney disorders; infection by the Acquired Immune Deficiency Syndrome (HIV) virus (if permitted by law); immune disorders; or the presence of medications, drugs, nicotine or other metabolites. The tests will be done by a medically accepted procedure which is extremely reliable.

If an HIV Antibody Screen is performed, it will be performed only by a certified laboratory and according to the following medical protocol:

1. An initial ELISA test will be done.
   a. If the initial ELISA test is positive, it will be repeated.
   b. If the initial ELISA test is negative, a negative finding will be reported to the Company.
2. If the initial ELISA test is positive, it will be repeated.
   a. If the second ELISA test is also positive, a Western Blot test will be performed to confirm the positive results of the two ELISA tests.
   b. If the second ELISA test is negative, a third ELISA test will be performed. If the third ELISA test is positive, a Western Blot test will be performed to confirm the previous positive results. If the third ELISA test is negative, a negative result will be reported to the Company.
3. Only if at least two ELISA tests and a Western Blot test are all positive will the result be reported as positive. All other results will be reported as negative to the Company.

Without a court order or written authorization from me, these results will be made known only to the Company and/or its reinsurers (if involved in the underwriting process). Positive test results to the HIV Antibody Screen will be disclosed only as I direct below. In addition, the Company may make a brief report to MIB, in a manner described in the Pre-notice which I received as a part of the application process. All the Company will report to MIB is that positive results were obtained from a test. The Company will not report what tests were performed or that the positive result was for HIV antibodies.

These organizations will be the only ones maintaining this information in any type of file except as required by law. In the event of an adverse underwriting decision, you may identify the person to whom the specific test results are disclosed.

(elect one) ☐ Alternative Testing Site ☐ my physician ☐ other: _____

Name and address of attending physician:

_____

_____

_____

_____

I have read and I understand this HIV Antibody Test and Informed Consent form. I voluntarily consent to the withdrawal of bodily fluids from me, the testing of those bodily fluids, and the disclosure of the test results as noted above.

This authorization will be valid 90 days from the date below.

Dated at: _____ , Month _____ , Day _____ , Year _____ .

Witness: _____
Producer (Signature)

Proposed Insured/
Parent or Guardian: _____
(Signature)

# New Business Transmittal / Fax Cover Sheet

1068

Life and Disability Insurance

**Ameritas Life Insurance Corp. of New York** P.O. Box 81889, Lincoln, NE 68501 / 877-280-6110, Fax 402-467-7335

## Agent/Representative Information

| | |
|---|---|
| Name | |
| Agency # | Agent # |
| State | |
| Telephone Number | Fax Number |
| Agent E-mail | |

## Client Information

| | |
|---|---|
| Name | |
| Date of Birth | |
| Social Security Number | |
| Date | Number of pages being faxed |

**Product(s) being applied for:** ☐ VUL ☐ WL ☐ Term ☐ UL ☐ Survivorship ☐ DI ☐ Other_____

**Is this a Combo Life & DI application?** ☐ Yes ☐ No

## Enclosures: (Check all items to be faxed or to follow)

| Attached | To Follow | | Attached | To Follow | |
|---|---|---|---|---|---|
| ☐ | ☐ | Application | ☐ | ☐ | APS – Doctor/Facility |
| ☐ | ☐ | Check (Amount of check $_____ ) | ☐ | ☐ | EFT Form with voided check |
| ☐ | ☐ | **Teleunderwriting / EZ App Order #** _____ | ☐ | ☐ | Income Documentation |
| ☐ | ☐ | LabSlip | ☐ | ☐ | Replacement / 1035 Exchange ***(mail original)*** |
| ☐ | ☐ | Part II Med or Paramed | ☐ | ☐ | **Illustration / UN 0008** |
| ☐ | ☐ | EKG | ☐ | ☐ | Licensing Paperwork |
| ☐ | ☐ | IR / PHI Order# _____ | ☐ | ☐ | Other _____ |

Comments:_____

## DO NOT MAIL ORIGINAL APPLICATION

**Please Note:**

- One application per fax transmission. **Fax to 402-467-7335.**
- Before faxing 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 81889, Lincoln, NE 68501.
- **Express Mail to** Client Service Office, 5900 O Street, Lincoln, NE 68510.

ATTACH CHECK HERE

Original check must be received in 10 days.

# Electronic Fund Transfer (EFT)

1150

**Ameritas Life Insurance Corp. of New York ("Company")** P.O. Box 81889, Lincoln, NE 68501 / 877-280-6110, Fax 402-467-7335

Insured Name _____

| Product Applied for/ Policy Number | Print Name of Insured | Monthly Premium | Monthly Loan Payment | New Policies Only: Initial Deduction |
|---|---|---|---|---|
| | | $ | $ | $ |
| | | $ | $ | $ |
| | | $ | $ | $ |
| | | $ | $ | $ |

Effective Month and Day to begin automatic withdrawals: _____ / _____
Month / Day

**On Universal Life and Variable Life policies, the Withdrawal Date must be on or prior to the policy date and cannot be after the 28th. On Index UL Policies, the Withdrawal Date must be on the 10th or 25th of the month.**

**New Policies ▶ ONLY ▶**

Monthly Initial Premium Amount $_____ to be electronically transferred*? ☐ Yes ☐ No
If No, and check is being mailed separately, make all checks payable to the Company.

One-time initial draft for direct billing mode premium amount $_____
(check one): ☐ Quarterly ☐ Semi-Annual ☐ Annual

* EFT not available for Initial Premium on Annuity products. Review the receipt to verify if the Proposed Insured qualifies to submit premium with the application. Note: Signing the Electronic Fund Transfer form does not mean that insurance is effective. Insurance is effective only if requirements of the Application for Insurance Receipt are satisfied. Note: If more than one policy, please complete first section above.

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): ☐ Checking ☐ Saving ☐ Credit Union

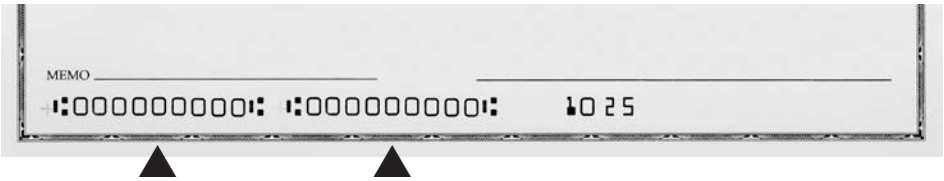
Add to existing EFT? ☐ Yes ☐ No

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

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

_____ _____
Transit/ABA Routing Number Bank Account Number

- Refer to the check diagram below to help determine your bank routing number and bank account number.




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

*** For Variable Life contracts and any Annuity contracts, a copy of a Pre-printed Voided Check is required.** In some other circumstances we will require a copy of a Pre-printed Voided Check or a letter from the bank indicating the ABA Routing Number, Account Number, and the Account Holder's Name for verification.

**IT IS UNDERSTOOD THAT:** Either or both of the above arrangements may be terminated by the Policy Owner or by the Company upon written notice. If the Bank Account Holder ("Payor") is other than the Policy Owner, the Company will terminate either or both of the arrangements upon written request of such Payor. Should the Premiums cease to be paid by Electronic Payment, the Company will accept payment of quarterly, semiannual or annual premium payments at the Company's published rates in effect as of the date of the policy.

For Policies Earning Dividends: Dividends cannot be used to offset Electronic Premium Payments. If dividends are currently being used to reduce premiums, please submit a dividend change form (UN 3379 B).

As a convenience to me (Payor and undersigned), I hereby request and authorize the Company, to pay and charge to my account checks, drafts or orders, whether by electronic or paper means, drawn on my account by the Company to its own order. This authorization will remain in effect until revoked by me in writing, and until the Company actually receives such notice I agree that the Company shall be fully protected in honoring any such order.

I (Payor and undersigned) understand that premium payments are necessary to fund the policy. If my financial institution does not honor a withdrawal, I may be required to send the Company a replacement payment. If the Company does not receive a replacement payment within the time required, the policy may enter its grace period and then lapse. Once a policy lapses, it no longer offers life insurance coverage.

The bank shall be under no obligation to furnish me (Payor and undersigned) with any special advice or notice in writing or otherwise of the payment and charge of such checks, drafts, or orders to my account.

**Declaration:** By signing this form I certify that I am an authorized signature for the bank account listed above.

➔

_____ _____ _____
**Signature of Bank Account Holder** Date Phone Number of Bank Account Holder