Application for Insurance Personal Information

1010

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

1. Proposed Insured (One):

To the best of the applicant's knowledge and belief:

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 or civil union partner? . . . . . ☐ Yes ☐ No

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

k) Are you a U.S. Citizen: ☐ Yes ☐ No

If "No," provide the following:

Copy of valid Passport and Visa

Citizenship: _____

Visa Type: _____ Visa #: _____

Number of years residing in U.S.:_____

l) Employer Name:_____

Address: _____

City: _____ State: ____ ZIP:_____

m) Occupation: _____ Years:_____

n) Duties:_____

o) Secondary Addressee:

Name: _____

Address: _____

City: _____ State: ____ ZIP:_____

2. Owner Information (One):

(complete only if Owner is other than Proposed Insured)

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

d) ☐ Corporation: County of Incorporation: _____
(complete Form UN 1166)

e) Full Name: _____

f) Relationship to Proposed Insured(s):_____

g) Trustee(s) Name: _____

h) Date of Birth or Date of Trust: _____

i) Social Security/Tax ID No.:_____

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

_____ State:_____

k) Address: _____

_____

City: _____ State: _____ ZIP: _____

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

Fax: _____ E-mail: _____

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

n) Are you a U.S. Citizen: ☐ Yes ☐ No

If "No," provide the following:

Copy of valid Passport and Visa

Citizenship: _____

Visa Type:_____ Visa #:_____

Number of years residing in U.S.:_____

o) Multiple Ownership *(indicate type)*:

☐ Joint with Survivorship

☐ Tenants in Common

p) Successor Owner:

Name: _____

Social Security/Tax ID No.:_____

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

a) Primary Beneficiary:_____

_____

Address: _____

City: _____ State:_____ ZIP:_____

Relationship to Proposed Insured: _____

Social Security/Tax ID:_____

Date of Birth or Date of Trust: _____

b) Contingent Beneficiary: _____

_____

Address: _____

City: _____ State:_____ ZIP:_____

Relationship to Proposed Insured: _____

Social Security/Tax ID:_____

Date of Birth or Date of Trust: _____

Application for Insurance Policy Details for Universal Life / Traditional Life

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

1. Universal Life:

a) Specified Amount *(base only)*: $_____ Plan of Insurance: _____

b) Index UL: Complete Supplement for Index UL Products.

c) Death Benefit Option: ☐ Option A *(Specified Amount)* ☐ Option B *(Specified Amount plus Account Value)* ☐ Option C *(Return of Premium)*

d) Life Insurance Qualification Test: ☐ GPT *(Guideline Premium Test)* ☐ CVAT *(Cash Value Accumulation Test)*

e) Planned Periodic Premium *(modal)*: $_____ Additional First-Year Premium *(lump-sum deposits)*: $_____

f) Single Life Supplementary Benefits:

☐ Accidental Death Benefit Rider . . . $_____
☐ Accounting Benefit Rider . . . . . $_____
☐ Children's Insurance Rider . . . . . $_____
☐ Guaranteed Insurability Rider . . . . $_____
☐ Scheduled Increase Rider . . . . . _____ %
☐ Supplemental Coverage Rider . . . . $_____
☐ Term Insurance Rider . . . . . $_____
☐ Total Disability Benefit Rider . . . . $_____
☐ Waiver of Monthly Deduction Rider
☐ Other: _____

g) Survivorship Supplementary Benefits:

☐ Estate Protection Rider ☐ Policy Split Rider
☐ Term Insurance Rider (Insured One) ☐ To Age: _____ ☐ Amount: $_____
☐ Term Insurance Rider (Insured Two) ☐ To Age: _____ ☐ Amount: $_____
☐ Total Disability Benefit Rider (Insured One) Amount: $_____ (Insured Two) Amount: $_____
☐ Waiver of Monthly Deduction Rider (Insured One) ☐ Waiver of Monthly Deduction Rider (Insured Two)

2. Term Life:

a) Specified Amount: $_____

b) Plan of Insurance: ☐ Term 1 ☐ Term 10 ☐ Term 15 ☐ Term 20 ☐ Term 30 ☐ Other: _____

c) Supplementary Benefits: ☐ Accidental Death Benefit Rider: $_____ ☐ Children's Insurance Rider: $_____
☐ Waiver of Premium Rider ☐ Other: _____

3. Whole Life:

a) Specified Amount: $_____ Plan of Insurance: _____

b) Dividend Option: ☐ Paid-Up Additions ☐ Cash ☐ Accumulate at Interest *(complete IRS Form W9)*
☐ Reduce Premium *(not on monthly modes)* ☐ One-Year Term

c) Nonforfeiture Option: ☐ Extended Term Insurance ☐ Reduce Paid-Up ☐ Automatic Premium Loan

d) Supplementary Benefits:

☐ Accidental Death Benefit Rider . . . $_____
☐ Children's Insurance Rider. . . . . $_____
☐ Flexible Paid-Up Rider:
☐ Single Premium . . . . . $_____
☐ Scheduled Premium . . . . . $_____
Premium Frequency: ☐ Annual ☐ Semi-Annual
☐ Quarterly ☐ Electronic Fund Transfer *(complete EFT form)*
☐ Salary Allotment ☐ Other: _____
☐ Guaranteed Insurability Rider . . . . $_____
☐ Level Term Rider . . . . . $_____
☐ 10 yr ☐ 15 yr ☐ 20 yr ☐ 30 yr
☐ One-Year Term Rider . . . . . $_____
☐ Term Paid-Up Rider (TPL) . . . . . $_____
☐ Total Disability Benefit Rider . . . . $_____
☐ Waiver of Premium Rider
☐ Other: _____

4. Payor:

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

Name: _____ Relationship: _____
Address: _____ Purpose: _____

b) Send Premium Notices to: ☐ Residence ☐ Business

c) Premium Frequency: ☐ Annual ☐ Semi-Annual ☐ Quarterly
☐ Electronic Fund Transfer *(complete EFT form)* ☐ Salary Allotment ☐ Other: _____

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

If this is a request for a **one-time** initial draft of the direct modal premium, check here ☐ and complete EFT form.

Supplemental Application for Index UL

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

For Excel Index UL

Account Allocation:

_____% Fixed Account: a current interest rate.

_____% Capped Participation Account: a 100% participation rate on a limited percentage increase in the S&P 500 Index.

_____% Uncapped Participation Account: a lower participation rate on an unlimited percentage increase in the S&P 500 Index.

100 % Total

For Excel Plus Index UL

Premium Allocation (applies to premiums):

_____% Fixed Account: a current interest rate.

_____% Capped S&P 500: a 100% participation rate on a limited percentage increase in the S&P 500 Index.

_____% Uncapped S&P 500: a lower participation rate on an unlimited percentage increase in the S&P 500 Index.

_____% Capped Russell 2000: a 100% participation rate on a limited percentage increase in the Russell 2000 Index.

_____% Capped MSCI EAFE: a 100% participation rate on a limited percentage increase in the MSCI EAFE Index.

100 % Total

Renewal Allocation (applies to the ending value in each participation account):

Note: To renew into the same Index Options, leave the Renewal Allocation section blank.

_____% Fixed Account: a current interest rate.

_____% Capped S&P 500: a 100% participation rate on a limited percentage increase in the S&P 500 Index.

_____% Uncapped S&P 500: a lower participation rate on an unlimited percentage increase in the S&P 500 Index.

_____% Capped Russell 2000: a 100% participation rate on a limited percentage increase in the Russell 2000 Index.

_____% Capped MSCI EAFE: a 100% participation rate on a limited percentage increase in the MSCI EAFE Index.

100 % Total

Dollar Cost Averaging:

Dollars From: $_____ Fixed Account

To: _____% Capped S&P 500

_____% Uncapped S&P 500

_____% Capped Russell 2000

_____% Capped MSCI EAFE

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 monthly date after the receipt by the Client Service Office of this request. Minimum transfer is $100.

Application for Insurance Financial Information for Life Insurance

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

1. Existing and Pending Insurance - Proposed Insured(s):

	Proposed Insured One	Proposed Insured Two
a) Total insurance in force on the Proposed Insured(s).	$	$
b) Total insurance currently pending with all companies, including this application.	$	$
c) Of the above pending amount, how much do you intend to accept?	$	$

d) Provide information for each policy in force on the Proposed Insured(s). *(attach additional page if necessary)*

Proposed Insured: ☐ One ☐ Two

Company: _____

Group, Personal or Business: _____

Issue Date: _____ To Remain in Force? ☐ Yes ☐ No

Face Amount: _____

Proposed Insured: ☐ One ☐ Two

Company: _____

Group, Personal or Business: _____

Issue Date: _____ To Remain in Force? ☐ Yes ☐ No

Face Amount: _____

e) 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) _____

2. Financial Questions:

	Proposed Insured One	Proposed Insured Two
a) Gross annual earned income *(salary, commissions, bonuses, etc.)*	$	$
b) Gross annual unearned income *(dividend, interest, net real estate income, etc.)*	$	$
c) Household net worth	$	

d) In the last 5 years, has either of the Proposed Insured(s) or the business had any major financial problems *(bankruptcy, etc.)*?
☐ Yes ☐ No *(if "Yes," give details)*

_____

e) If Owner, other than the proposed insured, is an individual:

Net Worth $ _____

Net Annual Income $ _____

Total Family Income $ _____

f) If proposed insured is under 18 years of age:

Estimate parents' Net Worth $ _____

Estimate parents' Income $ _____

g) Purpose of Insurance: _____

3. Source of Premiums: *(check one or more)*

☐ Current Income ☐ Cash Savings ☐ Employer
☐ Securities ☐ Relative ☐ Premium Finance
☐ 1035 Exchange ☐ Sale of personal property or real estate
☐ Insurance/Annuities *(Loans/Withdrawals)*
☐ Insurance or annuity maturity value or death benefit
☐ Rollover/Transfer of 401(k), Pension Funds or Qualified Funds
☐ Other: _____

4. Statement of Intent:

a) 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

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

_____

c) 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)*

_____

d) Will the policy, if issued, be placed in a trust? ☐ Yes ☐ No
(if "Yes," give details and provide copy of trust)

_____

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

5. Business Insurance: *(complete for ALL Business Owned Insurance)*

	Current Year	Previous Year
a) Assets	$	$
b) Liabilities	$	$
c) Gross Sales	$	$
d) Net Income after taxes	$	$
e) Fair Market Value of the business	$	$

f) What percentage of the business is owned by Proposed Insured(s)? _____%

g) Are other partners/owners/executives being insured? ☐ Yes ☐ No

(if "Yes," give details) _____

6. Existing Insurance (Replacement):

a) Do you have any existing life insurance policies or annuity contracts? ☐ Yes ☐ No
(if "Yes," complete a Replacement Notice if required by State Law)

b) Will any life insurance policy or annuity contract presently in force with this or any other company be discontinued, reduced, changed, or replaced if insurance now applied for is issued? ☐ Yes ☐ No
(if "Yes," give details)

Company: _____ Policy No.: _____

Amount: $ _____ Date: _____

Type of Policy: _____

7. Insurance Producer's Replacement Statement:

a) To the best of your knowledge, does the applicant have any existing insurance policies or 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, disability income or overhead expense insurance, or any other accident and sickness insurance? ☐ Yes ☐ No
(if "Yes," give details)

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)*

_____

Application for Insurance Lifestyle Questionnaire

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

Lifestyle Questions:

(please provide details for "Yes" answers)

To the best of the applicant's knowledge and belief:

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, such as: cigarettes, cigars, cigarillos, a pipe, chewing tobacco, nicotine patches, and gum)* ☐ 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. Ever made any flights as: a pilot, student pilot, or crew member of any aircraft? *(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 charged with, or convicted of, or currently awaiting trial on the violation of any criminal law? ☐ Yes ☐ No
7. In the next year, any intention of 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
   ☐ Martial Arts
   ☐ Scuba diving
   ☐ Mountain climbing
   ☐ 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. ("Company") P.O. Box 81889, Lincoln, NE 68501 / 800-745-1112, Fax 402-467-7335

Name of Proposed Insured: _____

Health Questions. Please complete Details for "Yes" answers.

1. a) Height: ___ ft. ___ in. b) Weight: _____ lbs.
   c) Has your weight changed by more than 10 lbs. in the last twelve months? If yes, list amount gained or lost and reason for the change in weight. ☐ Yes ☐ No
2. To the best of the applicant's knowledge and belief, have you ever been medically evaluated for, diagnosed with or treated for:
   a) High blood pressure or high cholesterol levels? ☐ Yes ☐ No
   b) Disorder of the eyes, ears, nose or throat? ☐ Yes ☐ No
   c) 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
   d) Shortness of breath, chronic cough, bronchitis, asthma, emphysema, chronic obstructive pulmonary disease (COPD), sleep apnea, or chronic respiratory disorder? ☐ Yes ☐ No
   e) 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
   f) 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
   g) 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
   h) Diabetes, elevated blood sugar, thyroid, pituitary, adrenal or other endocrine (glandular) disorders? ☐ Yes ☐ No
   i) Disorder of the breasts, reproductive organs, or prostate? ☐ Yes ☐ No
   j) C-section, miscarriage, or complication of pregnancy? ☐ Yes ☐ No
   k) Arthritis, gout, lupus or disorder of or injury to the bones, muscles, wrists, hips, knees or other joints? ☐ Yes ☐ No
   l) Spinal, neck or back disorder or injury, including sprains, strains, or disc disorder? ☐ Yes ☐ No
   m) Mass, polyp, cyst, tumor or cancer? ☐ Yes ☐ No
   n) Allergies; disorder of the skin; anemia, bleeding, clotting or other disorder of the blood? ☐ Yes ☐ No
   o) Anxiety, depression, stress, attention deficit hyperactivity disorder (ADHD), eating disorder or other psychiatric or mental health disorder? ☐ Yes ☐ No
   p) Chronic fatigue, chronic pain, fibromyalgia, or fever of unknown cause? ☐ Yes ☐ No
3. Are you currently pregnant? If yes, list expected due date. ☐ Yes ☐ No
4. Other than noted above, have you within the past five years:
   a) Consulted or received treatment from a chiropractor? ☐ Yes ☐ No
   b) 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
   c) Been advised by a licensed medical professional to have any diagnostic test (excluding HIV), hospitalization, or surgery which has not been completed? ☐ Yes ☐ No
5. Within the past ten years, have you ever:
   a) Used marijuana, cocaine, heroin, barbiturates, tranquilizers, hallucinogens, amphetamines, narcotics or any other drug, except as legally prescribed by a physician? ☐ Yes ☐ No
   b) 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
   c) Consumed alcoholic beverages? If yes, specify extent. ☐ Yes ☐ No
6. Have you been diagnosed by a licensed medical professional as having Acquired Immune Deficiency Syndrome (AIDS)? ☐ Yes ☐ No
7. Have you or 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
8. Family History

	Age if Living	Age at Death	Cause of Death
Father			
Mother			
Brothers			
Sisters			

9. a) Name and address of personal or attending physician:

   _____

   _____

   _____

   b) Telephone: _____

   c) Date last consulted: _____

   Reason and any medication/treatment given:

   _____

   _____

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

   _____

   _____

For each "Yes" answer, give details. *(identify: question number, diagnosis, dates, duration, treatment, names and addresses of all attending physicians and medical facilities and attach additional sheet, if needed)*

Application for Insurance Agreement

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

Agreement

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

(a) the only statements to be considered as the basis of the policy are those contained in the application or in any amendment to the application;

(b) any prepayment made with this application will be subject to the provisions of the TEMPORARY INSURANCE AGREEMENT;

(c) if there is no prepayment made with this application, the policy will not take effect until:
- **(1) the first premium is paid during the lifetime of the proposed insured(s) and while his/her health and the facts and other conditions affecting their insurability remain as described in this application and Part II, if required; and**
- **(2) the policy is delivered to the Owner;**

(d) 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 the contract must be endorsed to so reflect; and

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

If applying for an indeterminate premium plan:

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

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

Fraud Notice

Any person who includes any false or misleading information on an application for an insurance policy is subject to civil and criminal penalties.

Dated at: _____
City State Month Day Year

_____
Print or Type Proposed Insured Name

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

_____
Print or Type Other Proposed Insured Name
(or Personal Representative if insured is a minor)

X _____
Signature of Other Proposed Insured

_____
Print or Type Owner if not Proposed Insured

X _____
Signature of Owner if not Proposed Insured

_____
Print or Type Insurance Producer Name

_____ _____ _____
Producer No. Sit. Code % Split

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

_____
Print or Type Insurance Producer Name

_____ _____ _____
Producer No. Sit. Code % Split

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

_____ _____
Agency Name Agency No.

_____
Print or Type Insurance Producer Name

_____ _____ _____
Producer No. Sit. Code % Split

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

_____ _____
Agency Name Agency No.

Application for Insurance Authorization

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

Authorization to Obtain and Disclose Information

I authorize any health care providers, pharmacy benefit manager, hospitals, insurers, MIB, 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, or tobacco, 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 Company, its reinsurers, or any other agent or agency acting on the Company's behalf.

I authorize the Company, or its 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 the MIB; (3) 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; (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 agree that the above data and facts will be used to: (1) underwrite an application for coverage; (2) obtain reinsurance; (3) resolve or contest any issues of incomplete, incorrect, or misrepresented information on the application identified above which may arise during the processing or review of the application, or any other application for insurance; (4) administer coverage and claims; and (5) complete a consumer report, investigative consumer report or telephone interview about the proposed insured or claimant.

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

I acknowledge receipt of Notice of Insurance Information Practices.

Dated at: _____
City State Month Day Year

_____
Print or Type Proposed Insured Name

X _____
Signature of Proposed Insured

_____
Print or Type Other Proposed Insured Name

X _____
Signature of Other Proposed Insured

_____
Print or Type Name of Personal Representative of Proposed Insured

X _____
Signature of Personal Representative of Proposed Insured

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

Application for Insurance Producer's Statement

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

1. Background Information

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

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

c) Marital Status of the Insured:
- ☐ Single ☐ Married
- ☐ Divorced ☐ Widowed

2. Was this a Competitive Situation? ☐ Yes ☐ No

Competing Company: _____

3. Did you receive Home Office Assistance? ☐ Yes ☐ No

(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 minor brothers and sisters insured for an equal amount? . . . . . ☐ Yes ☐ No

Purpose of Insurance:

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

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

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

Association Discount: ☐ Yes ☐ No (*if "Yes," provide IPN.)*

Association IPN: _____

5. Was the application signed in the owner's resident state? ☐ Yes ☐ No

If "No" please provide us with reason why:

_____

_____

_____

_____

6. Request for Additional Life Policy(ies)

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

_____

_____

7. Underwriting Class Quoted

_____

_____

☐ Tobacco ☐ Nontobacco

8. Disability Income Insurance Information

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

* Preferred Occupation Premium

b) BOE Occupation Class Quoted:
- ☐ 6A ☐ 5A ☐ 4A ☐ 3A
- ☐ 6M ☐ 5M ☐ 4M ☐ 3M ☐ 2M

c) Discount (if applicable):
- ☐ Multi-life ☐ Association ☐ Big Case

IPN, if existing: _____

9. Producer Remarks

_____

_____

_____

_____

10. Producer's Certification *(must be Signed and Dated)*

I Certify that:

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

x _____

Signature of Insurance Producer

_____

Print Full Name of Insurance Producer

Insurance Producer Number: _____

Agency Number: _____

Temporary Insurance Agreement

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

This Temporary Insurance Agreement (TIA) may provide LIMITED coverage, as described herein, while we review the Proposed Insured's application (Application) to determine if we will issue the policy(ies) applied for. This TIA does not commit the Company to issue any policy(ies).

Part 1: Questions

Complete Sections A and B if applying for Life Insurance, Sections B and C if applying for Disability Income or Business Overhead Expense Insurance (Disability Insurance), and all three Sections if applying for both Life and Disability Insurance.

NO REPRESENTATIVE OF THE COMPANY IS AUTHORIZED TO ACCEPT MONEY IN CONSIDERATION FOR:

- **LIFE INSURANCE, if any of the questions in Sections A and B below are answered "Yes" or left blank with respect to the Proposed Insured, as NO life Insurance coverage will take effect under this TIA as a result of a blank or "Yes" answer; and**
- **DISABILITY INSURANCE, if any of the questions in Sections B and C below are answered "Yes" or left blank with respect to the Proposed Insured, as NO disability insurance coverage will take effect under this TIA as a result of a blank or "Yes" answer.**

A. If applying for Life Insurance:

1. Is the Proposed Insured less than 15 days old or above age 70? ☐ Yes ☐ No
2. Does the total amount of insurance applied for exceed $3,000,000? ☐ Yes ☐ No
3. Is the policy applied for a Survivorship life insurance policy? ☐ Yes ☐ No

B. If applying for Life and/or Disability Insurance:

Has the Proposed Insured:

1. In the past five years:
   a. Received treatment for, 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
2. In the past 90 days:
   a. Had any surgery, or been advised to have surgery, or been admitted to a hospital or medical facility, or been advised or referred by a licensed medical professional for admission to a hospital or medical facility? ☐ Yes ☐ No
   b. Had any diagnostic test, excluding tests for the Human Immunodeficiency Virus (HIV), for which the results are unknown, or been advised by a licensed medical professional to have any diagnostic test, excluding tests for HIV, which has not yet been completed? ☐ Yes ☐ No

C. If applying for Disability Insurance, also answer the following:

1. Is the Proposed Insured above age 60? ☐ Yes ☐ No
2. In the past five years, has the proposed insured received treatment for, been advised to seek treatment for, or been diagnosed by a licensed medical professional as having any of the following: diabetes; an emotional or mental disorder; or any disease, disorder or problem of the kidneys, arteries, neck, or back? ☐ Yes ☐ No
3. Within the past 12 months, has the proposed insured applied for, been declined for, or had issued any other individual disability insurance? ☐ Yes ☐ No

Part 2: Limited Coverage

No matter how much insurance has been applied for or how much of an advanced payment has been made, this TIA provides limited coverage as described below. Additionally, this TIA does not provide or cover any additional benefits or riders that may have been applied for in the Application.

A. Life Insurance: If the Proposed Insured dies during the TIA coverage period, any liability of the Company may not exceed the lesser of: (a) the initial base amount applied for in the Application; or (b) **$1,000,000**.

B. Disability Insurance: If the Proposed Insured becomes disabled during the TIA coverage period, any liability of the Company under this and any other agreements for Disability Income or Business Overhead Expense Insurance, will be limited as follows:

The monthly benefit will be the lesser of: (a) the amount of base benefit applied for in the Application, or (b) the amount of base benefit that would have been offered subject to current Company underwriting guidelines, or (c) **$5,000**.

The maximum benefit period provided under this TIA will be the shorter of: (a) the benefit period applied for in the Application or (b) 24 months.

Benefits will begin to accrue on the later of the day after the elimination period applied for is met or the 91st day of continuous total disability.

Part 3: Coverage Period

Coverage begins when the Application and this TIA have been completed and signed, a premium has been properly accepted as limited by Part 1 of this TIA, and the terms and conditions of this TIA have been met.

Coverage ends automatically on the earliest of the following dates:

1. 75 days after the date of this TIA,
2. The date coverage starts under any policy resulting from the Application,
3. Ten (10) days after the Company has approved the Application as other than applied for,
4. Five (5) days after the Company mails a notice that the Application is either declined or withdrawn, or
5. The day the Company refunds your premium.

Part 4: Limitations

1. **The Company's Liability:** Except as limited by this TIA, the Company's liability is governed by the terms and conditions of the policy(ies) for which you would have qualified based on current Company occupational and financial underwriting guidelines.
2. **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. **Survivorship:** No coverage is provided under this TIA and no premium can be accepted in consideration for Survivorship life insurance.
5. **Disability Insurance:** No coverage is provided under this TIA for: (a) accidental bodily injury that occurs or sickness that first manifests before coverage begins under this TIA, or (b) occupations considered uninsurable based on current Company underwriting guidelines.
6. **Coverage: No coverage is provided for anyone other than the Proposed Insured.**
7. **Other:** If any provision of this TIA is not enforceable under state law, all other terms and conditions shall continue in full force and effect.

Part 5: Premium Payment

Make all checks or other forms of payment payable to **Ameritas Life Insurance Corp.** The minimum premium required for coverage under this TIA is the amount equal to the one-month premium for the Policy(ies) applied for regardless of payment mode.

RECEIVED from _____ this _____ day of _____ , in the year of _____ ,

by check, or Electronic Fund Transfer (EFT) authorization, the amount of $_____ (Life Insurance) and/or

$_____ (Disability Insurance) in connection with the Application, which bears the same date as this TIA.

Part 6: Signatures

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

I have read, understand, and agree to all the terms and conditions of this TIA and acknowledge receiving a copy of this TIA.

➔ _____

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

➔ _____

Signature of Proposed Owner
(if other than Proposed Insured)

➔ _____

Signature of Producer

Temporary Insurance Agreement

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

This Temporary Insurance Agreement (TIA) may provide LIMITED coverage, as described herein, while we review the Proposed Insured's application (Application) to determine if we will issue the policy(ies) applied for. This TIA does not commit the Company to issue any policy(ies).

Part 1: Questions

Complete Sections A and B if applying for Life Insurance, Sections B and C if applying for Disability Income or Business Overhead Expense Insurance (Disability Insurance), and all three Sections if applying for both Life and Disability Insurance.

NO REPRESENTATIVE OF THE COMPANY IS AUTHORIZED TO ACCEPT MONEY IN CONSIDERATION FOR:

- **LIFE INSURANCE, if any of the questions in Sections A and B below are answered "Yes" or left blank with respect to the Proposed Insured, as NO life Insurance coverage will take effect under this TIA as a result of a blank or "Yes" answer; and**
- **DISABILITY INSURANCE, if any of the questions in Sections B and C below are answered "Yes" or left blank with respect to the Proposed Insured, as NO disability insurance coverage will take effect under this TIA as a result of a blank or "Yes" answer.**

A. If applying for Life Insurance:

1. Is the Proposed Insured less than 15 days old or above age 70? ☐ Yes ☐ No
2. Does the total amount of insurance applied for exceed $3,000,000? ☐ Yes ☐ No
3. Is the policy applied for a Survivorship life insurance policy? ☐ Yes ☐ No

B. If applying for Life and/or Disability Insurance:

Has the Proposed Insured:

1. In the past five years:
   a. Received treatment for, 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
2. In the past 90 days:
   a. Had any surgery, or been advised to have surgery, or been admitted to a hospital or medical facility, or been advised or referred by a licensed medical professional for admission to a hospital or medical facility? ☐ Yes ☐ No
   b. Had any diagnostic test, excluding tests for the Human Immunodeficiency Virus (HIV), for which the results are unknown, or been advised by a licensed medical professional to have any diagnostic test, excluding tests for HIV, which has not yet been completed? ☐ Yes ☐ No

C. If applying for Disability Insurance, also answer the following:

1. Is the Proposed Insured above age 60? ☐ Yes ☐ No
2. In the past five years, has the proposed insured received treatment for, been advised to seek treatment for, or been diagnosed by a licensed medical professional as having any of the following: diabetes; an emotional or mental disorder; or any disease, disorder or problem of the kidneys, arteries, neck, or back? ☐ Yes ☐ No
3. Within the past 12 months, has the proposed insured applied for, been declined for, or had issued any other individual disability insurance? ☐ Yes ☐ No

Part 2: Limited Coverage

No matter how much insurance has been applied for or how much of an advanced payment has been made, this TIA provides limited coverage as described below. Additionally, this TIA does not provide or cover any additional benefits or riders that may have been applied for in the Application.

A. Life Insurance: If the Proposed Insured dies during the TIA coverage period, any liability of the Company may not exceed the lesser of: (a) the initial base amount applied for in the Application; or (b) **$1,000,000**.

B. Disability Insurance: If the Proposed Insured becomes disabled during the TIA coverage period, any liability of the Company under this and any other agreements for Disability Income or Business Overhead Expense Insurance, will be limited as follows:

The monthly benefit will be the lesser of: (a) the amount of base benefit applied for in the Application, or (b) the amount of base benefit that would have been offered subject to current Company underwriting guidelines, or (c) **$5,000**.

The maximum benefit period provided under this TIA will be the shorter of: (a) the benefit period applied for in the Application or (b) 24 months.

Benefits will begin to accrue on the later of the day after the elimination period applied for is met or the 91st day of continuous total disability.

Part 3: Coverage Period

Coverage begins when the Application and this TIA have been completed and signed, a premium has been properly accepted as limited by Part 1 of this TIA, and the terms and conditions of this TIA have been met.

Coverage ends automatically on the earliest of the following dates:

1. 75 days after the date of this TIA,
2. The date coverage starts under any policy resulting from the Application,
3. Ten (10) days after the Company has approved the Application as other than applied for,
4. Five (5) days after the Company mails a notice that the Application is either declined or withdrawn, or
5. The day the Company refunds your premium.

Part 4: Limitations

1. **The Company's Liability:** Except as limited by this TIA, the Company's liability is governed by the terms and conditions of the policy(ies) for which you would have qualified based on current Company occupational and financial underwriting guidelines.
2. **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. **Survivorship:** No coverage is provided under this TIA and no premium can be accepted in consideration for Survivorship life insurance.
5. **Disability Insurance:** No coverage is provided under this TIA for: (a) accidental bodily injury that occurs or sickness that first manifests before coverage begins under this TIA, or (b) occupations considered uninsurable based on current Company underwriting guidelines.
6. **Coverage: No coverage is provided for anyone other than the Proposed Insured.**
7. **Other:** If any provision of this TIA is not enforceable under state law, all other terms and conditions shall continue in full force and effect.

Part 5: Premium Payment

Make all checks or other forms of payment payable to **Ameritas Life Insurance Corp.** The minimum premium required for coverage under this TIA is the amount equal to the one-month premium for the Policy(ies) applied for regardless of payment mode.

RECEIVED from _____ this _____ day of _____ , in the year of _____ ,

by check, or Electronic Fund Transfer (EFT) authorization, the amount of $_____ (Life Insurance) and/or

$_____ (Disability Insurance) in connection with the Application, which bears the same date as this TIA.

Part 6: Signatures

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

I have read, understand, and agree to all the terms and conditions of this TIA and acknowledge receiving a copy of this TIA.

➔ _____

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

➔ _____

Signature of Proposed Owner
(if other than Proposed Insured)

➔ _____

Signature of Producer

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

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

Examiner: _____

Address: _____

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

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

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

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

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

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

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

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

_____

This Notice and Consent is subject to revocation at any time except to the extent that the program which is to make the disclosure has already taken action in reliance on it. If not previously revoked, this Notice and Consent will be valid for a period not to exceed 365 days from the date it is signed.

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

Proposed Insured	Date of Birth

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

Non-Variable Life Policy

1041

Internal and External Replacement Form

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

Name of Policyholder:_____ Social Security #: _____

Name of Joint Policyholder: _____ Social Security #: _____

Policy number to be surrendered: _____

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

Agents 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 agent 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 agent in making recommendation to the client.

_____ _____

Owner Signature Date

_____ _____

Joint Owner Signature Date

_____ _____ _____

Agent Signature Agency # Date

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: Replacement of Life Insurance or Annuities

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

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

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

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

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

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

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

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

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

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

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

The existing policy or contract is being replaced because _____

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

_____ _____
Applicant's Signature and Printed Name Date

_____ _____
Joint Applicant's Signature and Printed Name Date

_____ _____
Producer's Signature and Printed Name Date

Initial

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

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

Premiums

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

Policy values

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

Insurability

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

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

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

If you are surrendering an annuity or interest sensitive life product

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

Other issues to consider for all transactions

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

Statement Identifying Use of Home Office Approved Sales Material

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

Proposed Insured Name: _____

Form Number*	Title of Sales Material

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

Soliciting Agent: _____

Soliciting Agent Number: _____

Date: _____

Exchange of Life Insurance Policy
Under Internal Revenue Code Section 1035(a)

1042

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

INSTRUCTIONS: Please complete Parts I and II.

PART I: Assignment of Ownership

This Section should be completed by owner:

Insured: _____

Owner (Assignor): _____ ☐ SSN or ☐ EIN _____

Policy number to be surrendered: _____

Policy issued by . . . . . Company Name: _____

(including address to correspond) Number and Street: _____

City, State, ZIP: _____

Assignee – Please transfer 100% of the surrender value unless otherwise indicated:

Ameritas Life Insurance Corp.
EIN: #47-0098400
$ or % of Surrender Value: _____

The Assignor intends that the sole purpose of this Assignment is to accomplish an exchange of insurance policies under Section 1035(a) of the Internal Revenue Code. This assignment, without limitation, specifically includes:

(1) the right to surrender the policy for its cash value, if any; and
(2) the right to transfer any and all rights received under this Assignment; and
(3) the right to receive death benefits, which may become payable under the policy; and
(4) the right to exercise all other policy rights and privileges; all without consent of the Assignor and without notice to the Assignor.

The Assignor hereby certifies and declares that no proceeding in bankruptcy is pending against the Assignor.

Therefore, the undersigned hereby designates the Company as beneficiary of the death benefits payable under the policy described above to the extent of the cash surrender value of the policy as of the date of the Insured's death. Any remaining death benefits shall be paid to the persons entitled thereto under the policy. Except as stated above, this beneficiary designation shall not affect or change any beneficiary designation previously recorded.

Immediately following the above beneficiary designation, for value received, the undersigned Assignor hereby absolutely assigns and transfers all rights, title and interest in the above policy to the Assignee, in exchange for a new life insurance policy or annuity contract which is described in the application for such new policy or contract that is submitted with this Agreement.

The Assignor has specifically requested the Assignee to participate in this transaction. The Assignor understands and agrees that the Assignee:

(1) Makes no representations and has no responsibility nor liability regarding the Assignor's tax treatment under Section 1035(a) of the Internal Revenue Code; and
(2) Does not guarantee the validity or sufficiency of this assignment.

*****Disclaimer Regarding Possible Taxation: Due to any unassumed loan balance or dividend or partial distributions, the exchange of your contract may not be tax free.**

Tax Withholding

If Federal Income Taxes are withheld from your payment, please note that some states have mandatory State Income Tax withholding which will also be deducted from your payment.

You must indicate if Federal Income Tax should not be withheld from your payment by completing the election below. Withholding will only apply to the portion of your payment that is taxable. If no box is marked, Federal Income Tax will be withheld.

Even if you elect not to have Federal Income Tax withheld, you are liable for payment of Federal Income Tax on the taxable portion of your disbursement. You also may be subject to tax penalties under the estimated tax payment rules if your payments of estimated tax and withholding, if any, are not adequate.

☐ DO ☐ DO NOT Withhold 10% Federal Income Tax from your payment

DECLARATIONS: The undersigned hereby declares that:
(1) I own the above policy and request the actions indicated, knowing community property law may require spouse consent; and
(2) No bankruptcy proceedings are now pending against the owner.

IMPORTANT: Please note, if the policyowner is a resident of a community property state (AZ, CA, ID, LA, NV, NM, TX, WA, and WI), the policyowner's spouse is required by that state to sign this form on the "Other Required Signature" line. The form will be returned if incomplete. If the policyowner has never been married, then please state "Not Married" on the "Other Required Signature" line. If the policyowner is divorced or the spouse is deceased, we will need verification of this for our records for future requests, i.e., certified copy of death certificate, certified copy of divorce decree.

Dated at _____ , this _____ day of _____ , year _____

Witness _____ Owners _____

Other Required Signature _____

Witness _____ Irrevocable Beneficiary(ies) _____

PART II: Return of Policy

This Section should be completed by owner:

☐ The policy is enclosed

☐ The undersigned declare(s) that the policy issued under the aforementioned number cannot be found. If found later, I/we agree to return it to the issuing Company without a claim.

Date_____ Owners _____

PART III: Surrender of Policy

This Section will be completed in the Home Office of the Company.

The Company, as assignee, accepts this assignment and hereby presents this policy for the surrender of its cash surrender value in order to effect an exchange and rollover for a new policy as permitted under Section 1035(a) of the Internal Revenue Code.

Please make the settlement check payable to the Company and mail to the following:
Ameritas Life Insurance Corp.
P.O. Box 81889
Lincoln, NE 68501

It is our understanding that the issuer of the policy(ies) being exchanged is required under IRC Section 1035(a) to provide us with the information sufficient to establish the cost basis. Please provide this information along with the settlement check. Also, please indicate whether the life insurance policy(ies) was a modified endowment contract (MEC) under IRC § 7702A.

The Assignee Company agrees that both the payment of the value requested in Part II and the furnishing of the investment in the contract (cost basis) will be in full settlement of all claims and right of any obligations.

Date:_____

By: _____

Please identify your remittance with the policy number:_____

Policy Illustration Certification

1045

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

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 agent acknowledge:

1. Either no policy illustration was used when recommendations were made by my agent 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.

Applicant *(print name)*

X
Applicant's Signature

Date

Agent *(print name)*

Agency No.

X
Agent's Signature

Date

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

Instructions to Agent

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

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

RESET FORM 1150

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

Premium Mode Monthly EFT

Add to Existing EFT - provide Policy Number and Insured: _____

Withdrawal Date _____ (The withdrawal date must be on or before the policy date and cannot be after the 28th)

Policy Number / Product Applied for	Print Name of Insured	Monthly Premium	Draft Initial Premium
		$	☐ Yes ☐ No
		$	☐ Yes ☐ No
		$	☐ Yes ☐ No

Initial Modal Premium* Draft will occur on the issue date of the policy.

Policy Number / Product Applied for	Print Name of Insured	Initial Premium	Mode
		$	☐ Annual ☐ Semi-annual ☐ Quarterly
		$	☐ Annual ☐ Semi-annual ☐ Quarterly
		$	☐ Annual ☐ Semi-annual ☐ Quarterly

CHECK ONE

☐ Yes, with temporary coverage. I have applied for temporary coverage via the attached Temporary Insurance Agreement form. Premium will be drafted only after my application has been approved and the policy has been issued.

☐ Yes, without temporary coverage. Premium will be drafted only after my application has been approved and the policy has been issued. I understand that no temporary coverage will be in force during the underwriting process.

☐ No, I would like ongoing monthly premium drafts, but have included a check (payable to Ameritas Life) for the initial monthly premium.

*Review the Temporary Insurance Agreement to verify if the Proposed Insured qualifies to submit premium with the application. Note: Signing the Electronic Fund Transfer form does not mean that insurance is effective. Insurance is effective only if requirements of the Temporary Insurance Agreement are satisfied.

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

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

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

Transit/ABA Routing Number

Bank Account Number

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

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

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

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

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

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

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

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

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

➔

Signature of Bank Account Holder | Date | Phone Number of Bank Account Holder