Ameritas Life Insurance Corp.

Application for Disability Income Insurance

Instructions and Checklist

This packet includes an application for disability income insurance and the Notice of Insurance Information Practices. Forward the entire application to the Client Service Office intact.

Please be sure:

- ☐ The Notice of Information Practices is delivered to the proposed insured before completion of the application.
- ☐ All personal, financial, lifestyle, health and policy information sections are complete.
- ☐ The proposed insured reads and signs the Authorization to Obtain and Disclose Information.
- ☐ The proposed insured, owner (if other than the insured), and producer read and sign the Agreement page.
- ☐ The owner provides his/her Tax Identification Number (Social Security number) at the bottom of the Agreement page and certifies with a signature that it is correct. The owner is the same as the proposed insured in most instances.
- ☐ All sections are complete on the Producer's Statement and the form has been signed.
- ☐ The Conditional Receipt is given to the premium payor whenever full initial premium is collected from the proposed insured. Premium payment must be made by personal check only. No cash, money orders, traveler's checks, or bank checks are permitted.

Application Kit	Notice of Insurance Information Practices – Provide to Proposed Insured
	Personal Information
	Financial and Policy Information
	Policy Details – Provide only when selecting DInamic Foundation products
	Lifestyle and Health Questionnaire
	Authorization
	Agreement
	Producer's Statement
	Conditional Receipt

Ameritas Life Insurance Corp.

Application for Disability Income Insurance

Notice of Insurance Information Practices

To issue an insurance policy we need to obtain information about you, the proposed insured. Some of that information will come from you and some will come from other sources. We may obtain information relating to your 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. Ameritas Life Insurance Corp. (the Company) or its 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 Company or its reinsurers may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

Furthermore, as part of our procedure for processing your insurance application, an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends, associates, or others with whom you are acquainted.

This inquiry and any subsequent investigative consumer report update which may also be requested includes information as to your character, general reputation, personal characteristics, and mode of living.

You have the right to be personally interviewed if we order an investigative consumer report. Please notify our agent if this is your wish. You are also entitled to receive a copy of the investigative consumer report whether or not an interview is conducted. You also have the right to make a written request within a reasonable period of time to receive additional, detailed information about the nature and scope of this investigation.

To reduce costs and offer insurance coverage at the lowest possible premium, the Company may also use a Personal History Interview. A specially trained interviewer may call to discuss information contained in your application or to ask questions related to the underwriting of your insurance. We will attempt to conduct this telephone interview at your convenience and at a number you designate.

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

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

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

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

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

Ameritas Life Insurance Corp.

Application for Disability Income Insurance

Personal Information

1. Proposed Insured

a) Name: _____ b) Gender: ☐ Male ☐ Female

c) Address: _____ d) Daytime Phone: _____

e) Social Security/Tax ID Number: _____ f) Driver's License Number: _____ State: _____

g) Date of Birth: _____ h) Place of Birth: _____

i) Are you a U.S. Citizen or Permanent Resident? ☐ Yes ☐ No If "No," Citizenship: _____ Visa Type: _____

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

a) ☐ Individual ☐ Trust *(provide copy)* ☐ Partnership ☐ Corporation: County of Incorporation: _____

b) Name: _____

c) Address: _____ d) Daytime Phone: _____

e) Social Security/Tax ID Number: _____ f) Driver's License Number: _____ State: _____

g) Date of Birth: _____ h) Relationship to Proposed Insured: _____

i) Are you a U.S. Citizen or Permanent Resident? ☐ Yes ☐ No If "No," Citizenship: _____ Visa Type: _____

j) Trustee(s) Name(s): _____ k) Date of Trust: _____

3. Beneficiary Information (in the event benefits are payable after death)

a) Primary Beneficiary: _____ Date of Birth or Trust: _____

Address: _____

Relationship to Proposed Insured: _____ Social Security/Tax ID Number: _____

b) Contingent Beneficiary: _____ Date of Birth or Trust: _____

Address: _____

Relationship to Proposed Insured: _____ Social Security/Tax ID Number: _____

4. Occupation

a) Primary Employer: _____

b) Address: _____

c) Current occupation(s): _____ d) Years: _____ e) Business Phone: _____

f) Physical/Manual duties: _____% g) Description of occupational duties: _____

_____

h) Do you work at least 30 hours per week in your primary occupation? ☐ Yes ☐ No

i) Within the past five years, has your professional license been suspended or revoked; or is your license under review; or have you been disbarred? ☐ Yes ☐ No

If "Yes," give details: _____

_____

j) If you work for another employer other than noted above, provide details *(name of employer, occupation, duties, years)*:

_____

_____

Ameritas Life Insurance Corp.

Application for Disability Income Insurance

Financial and Policy Information

1. Basic Financial Information

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

Annual Salary, Bonus, Variable Compensation *(W-2 wages)*:	$
Annual pension or profit sharing contribution from employer:	$
If business owner, your share of annual net business income *(after expenses)*:	$

b) Within the past two years, have you filed for personal or business bankruptcy; or had judgments against you? . . . . . ☐ Yes ☐ No

If "Yes," give details to include dates, amounts, location, and status: _____

_____

2. Existing Insurance

a) Do you have any other disability insurance that pays a lump sum benefit in force or pending with this company or any other insurance company? . . . . . ☐ Yes ☐ No

If "Yes," name of company and benefit amount: _____

b) Will any disability insurance with this company 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: _____

c) 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 disability income insurance, or any other accident and sickness insurance? . . . . . ☐ Yes ☐ No

If "Yes," give details. Company: _____

Policy Number: _____ Amount to be replaced: $_____

3. Premium

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

b) Address for Premium Notices: _____

c) Premium Frequency: ☐ Annual ☐ Monthly Electronic Funds Transfer *(complete EFT form)* ☐ Other: _____

Salary Allotment/List Bill (#: _____)

d) 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: $ _____

4. Policy Details - DInamic Fundamental

a) Benefit Amount *(lump sum payment)*: $_____

Ameritas Life Insurance Corp.

Application for Disability Income Insurance

Lifestyle and Health Questionnaire

Lifestyle Questions *(provide details for "Yes" answers below)*

1) Within the past 12 months, have you used tobacco or nicotine products in any form *(including nicotine patches/gum)*? ☐ Yes ☐ No
2) Within the past five years, have you had a driver's license revoked or suspended? ☐ Yes ☐ No
3) Have you been charged with, or convicted of, or currently awaiting trial for a felony violation of any criminal law? ☐ Yes ☐ No
4) Within the next two years, do you have any intention of residing outside of the U.S. or traveling outside of the U.S. or Canada? ☐ Yes ☐ No
5) Within the past two years, have you engaged in, or in the next twelve months do you plan to engage in, any hazardous activities *(such as scuba diving, motorized racing, skydiving, hang-gliding, mountain climbing, aviation)*? ☐ Yes ☐ No

Details for all "Yes" answers to Lifestyle Questions *(include question numbers, dates, etc.)*. Attach additional sheet, if needed.

Health Questions *(provide details for "Yes" answers below)*

1) Have you ever received or applied for disability insurance benefits due to sickness or injury? ☐ Yes ☐ No
2) Have you ever applied for insurance or reinstatement which has been declined, postponed, rated, modified, or had any such insurance canceled or a renewal premium refused? ☐ Yes ☐ No
3) Within the past six months, have you missed work due to, or been treated for, sickness or injury? ☐ Yes ☐ No
4) Have you been diagnosed with, medically treated for, or had any known indication of:
   a) heart attack, angina, coronary artery disease, stroke, mini-stroke, high blood pressure *(include last reading in details)* or any other type of heart or circulatory system disease? ☐ Yes ☐ No
   b) any form of cancer *(including leukemia, lymphoma, or cancer of the bone marrow)*? ☐ Yes ☐ No
   c) any chronic or progressive disease or disorder of the: kidneys, liver, lung or respiratory system, pancreas, muscles or connective tissue, joints, eyes, ears, bone marrow, digestive system, brain, nervous system or immune system; or have you been diagnosed with sleep apnea or diabetes *(non pregnancy related)*? ☐ Yes ☐ No
   d) seizures, anxiety, depression, Epstein-Barr virus, chronic fatigue, or fibromyalgia? ☐ Yes ☐ No
   e) spine, neck or back disease or disorder? ☐ Yes ☐ No
5) Have you been diagnosed by a licensed medical professional or tested positive for Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV)? ☐ Yes ☐ No
6) Are you taking any prescription medications on a regular basis? ☐ Yes ☐ No
7) Within the past ten years, have you used marijuana, cocaine, barbiturates, tranquilizers, heroin, LSD, amphetamines, morphine, narcotics, or any other drug except as legally prescribed by a physician, or sought or received treatment for the use of alcohol? ☐ Yes ☐ No
8) Within the past five years, other than noted above, have you been a patient in a hospital or other medical facility? ☐ Yes ☐ No
9) Your Height: _____ Your Weight: _____ Have you lost or gained 20 or more pounds in the past 12 months? ☐ Yes ☐ No

Provide details below for all "Yes" answers to Health Questions. Attach additional sheet, if needed.

Question Number	Description of Disorder, Disease or Injury	Month/Year of Diagnosis	Duration/Number of Episodes	Treatment, Degree of Recovery, and Remaining Problems or Symptoms	Name of Attending Physician and Date of Last Visit

Application for Disability Income Insurance

Authorization

Ameritas Life Insurance Corp.

Authorization to Obtain and Disclose Information

I, the proposed insured, authorize any health care provider, pharmacy benefit manager, hospital, insurer, 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 my physical or mental condition, medical care, advice, treatment, use of drugs, alcohol, 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 me; including wage and earnings, or data or facts with respect to other insurance coverage; to give all data or facts to Ameritas Life Insurance Corp. (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 MIB; (3) to persons performing business duties as directed or contracted for by the Company related to my 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 me.

I agree that this authorization is valid for 24 months 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 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.

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

Ameritas Life Insurance Corp.

Application for Disability Income Insurance

Agreement

Agreement

The undersigned represent that their statements in this application and Part II, if such Part II is required by Ameritas Life Insurance Corp. (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 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 and while his/her health and the facts and other conditions affecting his/her 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 Company's rights or requirements; and

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

Fraud Notice

Any person who knowingly or with intent to defraud; submits an application or files a claim containing false, incomplete or misleading information; is guilty of a crime and may be subject to fines and criminal penalties, including imprisonment. In addition, insurance benefits may be denied if false information provided by an applicant is materially related to a claim.

Dated at: _____
City State Month Day Year

_____
Print or Type Proposed Insured Name

X _____
Signature of 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

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)

Social Security Number	Employer Identification Number

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).

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

Ameritas Life Insurance Corp.

Application for Disability Income Insurance

Producer's Statement

1. Background Information

a) How well acquainted are you with the proposed insured?

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

b) Initial contact with proposed insured?

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

c) Marital Status of proposed insured:

☐ Single ☐ Divorced ☐ Married ☐ 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. Occupational Class Quoted

a) DInamic Fundamental - lump sum payment

☐ 1L - 50% or less manual duties
☐ 2L - more than 50% manual duties

b) DInamic Foundation - individual disability income

☐ 6A ☐ 5A ☐ 4A ☐ 3A ☐ 2A ☐ A ☐ B
☐ 6M ☐ 5M ☐ 4M ☐ 3M ☐ 2M ☐ M

5. Premium Quoted

a) DInamic Fundamental: $_____

b) DInamic Foundation: ☐ Required illustration attached

6. 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.
- All of the sales materials used have been approved in advance by the Home Office.
- I am familiar with Ameritas Life Insurance Corp.'s 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: _____

Ameritas Life Insurance Corp.

Application for Disability Income Insurance

Conditional Receipt

NOTICE TO PRODUCER

PREMIUM SHOULD NOT BE ACCEPTED IF THE PROPOSED INSURED IS OVER AGE 60, OR HAS EVER BEEN TREATED FOR HEART DISEASE, DIABETES, STROKE, OR CANCER, OR HAS BEEN ADMITTED TO A MEDICAL FACILITY WITHIN THE PAST 90 DAYS.

NOTICE TO PROPOSED INSURED

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 under this receipt. The "coverage date" is the date of this application or Part II of this application or medical examination or other tests required by published rules of Ameritas Life Insurance Corp. (the Company) used when considering the benefits applied for, whichever date is latest.

1. **Premium Payment**
   The premium taken with this application must be equal to the full first premium for the mode of premium and the applied for benefits.

2. **Insurability**
   As of the "coverage date," the Company's Underwriting Officer must find the 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. **Maximum Amount**
   The maximum benefits payable under this and any other receipts will be:
   a) for policies designed to pay a lump sum benefit, the lesser of: (i) the lump sum amount applied for in this application; (ii) the amount of lump sum benefit that would be offered subject to our Underwriting Guidelines then in effect; or (iii) $40,000 or;
   b) for other types of policies, the lesser of: (i) the amount of monthly benefits applied for in this application; (ii) the amount of monthly benefits that would be offered subject to our Underwriting Guidelines then in effect; or (iii) $5,000 per month of Disability Income, Social Insurance Substitute and Catastrophic Disability benefits combined.

4. **Termination of Conditional Insurance**
   If insurance is provided under this receipt, it will terminate on the date the policy is delivered to the applicant or the date a premium refund is mailed to the payor and/or a notice is sent that the application will no longer be considered on a pre-paid basis. If the applicant withdraws from consideration for coverage or refuses an offer of coverage or the application is declined by the Company, all premiums paid in connection with the policy will be refunded and no coverage will have been provided under this receipt.

5. **Limitations**
   a) **The Company's Liability:** Except as limited by this receipt, the Company's liability is governed by the terms of the policy applied for.
   b) **Suicide:** If the person proposed for insurance commits suicide while sane or insane, the Company's liability under this receipt will be limited to a refund of the premium payment submitted with the application.
   c) **Misrepresentation:** If there are any incorrect, untrue, incomplete, or omitted statement(s) of material fact in this application, any supplemental form(s), or medical questionnaire(s) that would become a part of the policy, no benefit will be payable under this receipt, and this receipt will become null and void. No knowledge of any fact on the part of any agent, 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) **Other:** If any provision of this receipt is not enforceable under state law, all other terms and conditions shall continue in full force and effect.

No insurance is provided under this Conditional Receipt unless all terms and conditions of this receipt are met. This receipt is void if there are any modifications made to the conditions of this receipt. This receipt is also void if the payment is made by a check or draft that is not honored when presented for payment. All premium checks must be made payable to the Company. Do not make checks payable to the insurance producer or present a blank check.

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 Proposed Insured

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

Ameritas Life Insurance Corp.

Application for Disability Income Insurance

Conditional Receipt

NOTICE TO PRODUCER

PREMIUM SHOULD NOT BE ACCEPTED IF THE PROPOSED INSURED IS OVER AGE 60, OR HAS EVER BEEN TREATED FOR HEART DISEASE, DIABETES, STROKE, OR CANCER, OR HAS BEEN ADMITTED TO A MEDICAL FACILITY WITHIN THE PAST 90 DAYS.

NOTICE TO PROPOSED INSURED

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 under this receipt. The "coverage date" is the date of this application or Part II of this application or medical examination or other tests required by published rules of Ameritas Life Insurance Corp. (the Company) used when considering the benefits applied for, whichever date is latest.

1. **Premium Payment**
   The premium taken with this application must be equal to the full first premium for the mode of premium and the applied for benefits.

2. **Insurability**
   As of the "coverage date," the Company's Underwriting Officer must find the 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. **Maximum Amount**
   The maximum benefits payable under this and any other receipts will be:
   a) for policies designed to pay a lump sum benefit, the lesser of: (i) the lump sum amount applied for in this application; (ii) the amount of lump sum benefit that would be offered subject to our Underwriting Guidelines then in effect; or (iii) $40,000 or;
   b) for other types of policies, the lesser of: (i) the amount of monthly benefits applied for in this application; (ii) the amount of monthly benefits that would be offered subject to our Underwriting Guidelines then in effect; or (iii) $5,000 per month of Disability Income, Social Insurance Substitute and Catastrophic Disability benefits combined.

4. **Termination of Conditional Insurance**
   If insurance is provided under this receipt, it will terminate on the date the policy is delivered to the applicant or the date a premium refund is mailed to the payor and/or a notice is sent that the application will no longer be considered on a pre-paid basis. If the applicant withdraws from consideration for coverage or refuses an offer of coverage or the application is declined by the Company, all premiums paid in connection with the policy will be refunded and no coverage will have been provided under this receipt.

5. **Limitations**
   a) **The Company's Liability:** Except as limited by this receipt, the Company's liability is governed by the terms of the policy applied for.
   b) **Suicide:** If the person proposed for insurance commits suicide while sane or insane, the Company's liability under this receipt will be limited to a refund of the premium payment submitted with the application.
   c) **Misrepresentation:** If there are any incorrect, untrue, incomplete, or omitted statement(s) of material fact in this application, any supplemental form(s), or medical questionnaire(s) that would become a part of the policy, no benefit will be payable under this receipt, and this receipt will become null and void. No knowledge of any fact on the part of any agent, 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) **Other:** If any provision of this receipt is not enforceable under state law, all other terms and conditions shall continue in full force and effect.

No insurance is provided under this Conditional Receipt unless all terms and conditions of this receipt are met. This receipt is void if there are any modifications made to the conditions of this receipt. This receipt is also void if the payment is made by a check or draft that is not honored when presented for payment. All premium checks must be made payable to the Company. Do not make checks payable to the insurance producer or present a blank check.

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 Proposed Insured

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

Certificate of Delivery

Ameritas Life Insurance Corp.

This acknowledges that the undersigned has this date made application for a _____ policy to be issued by Ameritas Life Insurance Corp. and that an Outline of Coverage of such policy was delivered to the undersigned at the time the application was made.

Date: _____

Signature: _____

New Business Transmittal / Fax Cover Sheet

1068

Life and Disability Insurance

Ameritas Life Insurance Corp.

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

☐ Term _____

▲ Provide existing policy numbers for **SAME PAYOR DISCOUNT** if applicable

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**
☐	☐	IR / PHI Order# _____	☐	☐	Licensing Paperwork

Comments: _____

DO NOT MAIL ORIGINAL APPLICATION

Please Note:

- One application per fax transmission.
- 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.

ATTACH CHECK HERE

Original check must be received in 10 days.

Electronic Fund Transfer (EFT)

Ameritas Life Insurance Corp. ("Company")

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 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

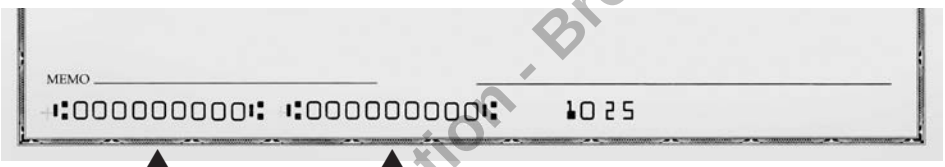
Add to existing EFT? ☐ Yes ☐ No

_____
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