UNIFI®
Companies

Application for Insurance
Instructions and Checklist

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

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

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

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

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

*If the coverage requested is within the Company's nonmedical limits, no other application forms are required. If the coverage requested exceeds our published nonmedical limits, a medical or paramedical examination should be obtained. For teleunderwriting (EZ App), you are not responsible for obtaining an exam. If you learn of any adverse information after the application has been submitted and before the policy is issued or delivered, you are required to report it immediately.

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

LIFE INSURANCE
DISABILITY INCOME INSURANCE

You have chosen important insurance coverage. The next step in the application process is a telephone interview so that you may provide your medical and lifestyle information in the comfort of your home or office. Our professional interviewer will contact you in the next 24-48 hours. This interview should take about 20 minutes to complete.

Telephone Interview

During the interview, you will be asked basic questions about yourself such as:

- Medical and prescription history
- Tobacco use
- Hobbies, travel and sports

This section has been provided as a convenient place to record your information. Please have the information below available at the time of the interview to expedite the process.

Names, addresses and phone numbers of physicians and medical facilities that have provided you with medical care:

_____

_____

Diagnosis and dates of any significant medical conditions:

_____

_____

Prescribed medications, including dosage and frequency:

_____

_____

Driver's license number and state of issue:

_____

Mini-Examination

A mini-examination (mini-exam) may be required to complete the application process. The telephone interviewer will schedule a visit (if necessary) from a qualified medical professional to collect height, weight, blood pressure, pulse, a blood and urine sample, and, in some instances, an electrocardiogram (EKG). This mini-exam may be performed at your convenience in the privacy of your home, office, or an independent medical facility, if one is available in your area. Please have your calendar available to help identify the most convenient date and time for your mini-exam. If you have any questions, please contact your insurance representative. If a mini-exam is required, use this space to write down the time and date of the mini-exam:

_____

_____

Mini-Exam Tips: Please follow these suggestions prior to your exam.

- Abstain from eating or drinking (except water) for 12 hours prior to your mini-exam, if your health permits.
- Do not drink alcoholic beverages for 12 hours prior to your mini-exam.
- Do not smoke or chew tobacco for at least one hour prior to your mini-exam.
- Do not engage in strenuous physical activity 12 hours prior to your mini-exam.

You have the right to review your entire application and make corrections at any time prior to an underwriting decision. For a copy of the application, please contact your financial professional.

This information is provided by The Union Central Life Insurance Company and Ameritas Life Insurance Corp. of New York, each a UNIFI® company. Each company is solely responsible for its own financial condition and contractual obligations. For more information about UNIFI® Companies, visit UNIFIcompanies.com.

AMERITAS LIFE INSURANCE CORP. OF NEW YORK
A UNIFI Company

1350 Broadway, Suite 2201
New York, NY 10018
AmeritasNY.com

UnionCentral
A UNIFI Company

Home Office
5900 O Street, Lincoln, NE 68510

Client Service Office
1876 Waycross Road, Cincinnati, OH 45240
www.unioncentral.com

UNIFI
Companies

Application for Insurance

Notice of Insurance Information Practices

Ameritas Life Insurance Corp. of New York
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877-280-6110, Fax 513-595-2352
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To issue an insurance policy we need to obtain information about you and any other persons proposed for insurance. Some of that information will come from you and some will come from other sources. We may obtain information relating to any proposed insured's mental and physical health, general character and reputation, habits, finances, occupation, other insurance coverage, or participation in hazardous activities.

This information may be obtained from physicians, medical professionals, hospitals, clinics or other medical care institutions, or from the Medical Information Bureau, Inc. (MIB), public records, consumer reporting agencies, financial sources, other insurance companies, agents, friends, neighbors and associates. We may obtain information through exchanges or correspondence, by telephone or by personal contact.

Information regarding your insurability or claims will be treated as confidential. The companies listed above ("the Companies") or their reinsurers may, however, make a brief report thereon to the Medical Information Bureau, Inc. (MIB), a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file. Upon receipt of a request from you, the MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the MIB's information office is 50 Braintree Hill, Suite 400, Braintree, Massachusetts 02184-8734; telephone number (866) 692-6901 (TTY 866-346-3642); website address www.mib.com. The Companies or their reinsurers may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

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

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

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

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

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

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

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

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

DETACH AND DELIVER TO PROPOSED INSURED BEFORE COMPLETION OF THE APPLICATION

AMERITAS
LIFE INSURANCE CORP.
OF NEW YORK
A UNIFI Company

Application for Insurance
Personal Information

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

1. Proposed Insured (One):

a) Name: _____

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

d) Place of Birth: _____

e) Social Security/Tax ID No.: _____

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

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

h) Years at this Address: _____

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

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

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

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

m) Occupation: _____ Years:_____

n) Duties: _____

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

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

d) ☐ Corporation: County of Incorporation: _____

e) Full Name: _____

f) Relationship to Proposed Insured(s):_____

g) Trustee(s) Name:_____

h) Date of Birth or Date of Trust: _____

i) Social Security/Tax ID No.: _____

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

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

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

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

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

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

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

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

a) Primary Beneficiary: _____
_____
Address:_____
City: _____ State:____ ZIP:_____
Relationship to Proposed Insured:_____
Social Security/Tax ID:_____
Date of Birth or Date of Trust: _____

b) Contingent Beneficiary: _____
_____
Address:_____
City: _____ State:____ ZIP:_____
Relationship to Proposed Insured:_____
Social Security/Tax ID:_____
Date of Birth or Date of Trust: _____

AMERITAS LIFE INSURANCE CORP. OF NEW YORK
A UNIFI Company

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

Application for Insurance
Personal Information (continued)

1. Proposed Insured (Two):

a) Name: _____

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

d) Place of Birth: _____

e) Social Security/Tax ID No.: _____

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

_____ State: _____

g) Home Address: _____

City: _____ State:____ ZIP:_____

h) Years at this Address: _____

i) Tel. *(Home)*: _____

(Business):_____

Fax: _____

E-mail: _____

Best time to call: _____ at: ☐ Business ☐ Home
In the event you are not available when our interviewer calls, may we speak with your spouse? ☐ Yes ☐ No

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

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

Citizenship: _____

Visa Type:_____ Visa #: _____

l) Employer Name: _____

Address:_____

City: _____ State:____ ZIP:_____

m) Occupation: _____ Years:_____

n) Duties: _____

2. Owner Information (Two):

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

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

d) ☐ Corporation: County of Incorporation: _____

e) Full Name: _____

f) Relationship to Proposed Insured(s):_____

g) Trustee(s) Name:_____

h) Date of Birth or Date of Trust: _____

i) Social Security/Tax ID No.: _____

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

_____ State: _____

k) Address:_____

City: _____ State:____ ZIP:_____

l) Tel. *(Home)*: _____

(Business):_____

Fax: _____

E-mail: _____

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

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

Citizenship: _____

Visa Type:_____ Visa #: _____

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

p) Successor Owner:

Name: _____

Social Security/Tax ID No.: _____

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

a) Name: _____

b) Relationship: _____

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

e) Place of Birth: _____

f) Social Security No: _____

g) Ins. in Force/Company: _____

h) Driver's License No:_____

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

a) Name: _____

b) Relationship: _____

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

e) Place of Birth: _____

f) Social Security No: _____

g) Ins. in Force/Company: _____

h) Driver's License No:_____

AMERITAS LIFE INSURANCE CORP. OF NEW YORK
A UNIFI Company

Disability Income
Policy Details

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

1. Individual Disability Income Insurance:

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

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

c) Base Monthly Benefit: $ _____

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

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

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

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

2. Business Overhead Expense (5503-BOE):

a) Maximum Base Monthly Benefit: $ _____

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

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

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

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

3. Premium:

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

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

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

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

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

Individual Disability Income: $_____
Business Overhead Expense: $_____
Total: $_____

4. Business Ownership:

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

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

c) If "Yes," how many other owners or partners are there? ___

5. Occupation / Employment:

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

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

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

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

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

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

g) If "Yes," what percentage will be paid by the employer?__%

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

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

UNIFI
Companies

Application for Insurance

Authorization

Ameritas Life Insurance Corp. of New York
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Authorization to Obtain and Disclose Information

I authorize any health care providers, hospitals, insurers, the Medical Information Bureau, Inc. ("MIB"), consumer reporting agency, government agency, financial institution, and/or accounting, educational institution, or employer; having data or facts about the proposed insured's or claimant's physical or mental condition, medical care, advice, treatment, the use of drugs, alcohol, (except for substance abuse treatment program records for which special authorization is required) or tobacco, HIV, AIDS and sexually transmitted diseases, prescription drug records, financial status, education records, or employment status or other relevant data or facts about the proposed insured or claimant; including wage and earnings, or data or facts with respect to other insurance coverage; to give all data or facts to the companies listed above ("the Companies"), their reinsurers, or any other agent or agency acting on the Companies' behalf.

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

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

I acknowledge receipt of Notice of Insurance Information Practices.

Dated at: _____
City State Month Day Year

_____
Print or Type Name of Proposed Insured

X _____
Signature of Proposed Insured

_____
Print or Type Name of Other Proposed Insured

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.)

This Authorization complies with the HIPAA Privacy Rules.

UNIFI Companies

Application for Insurance

Agreement

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Agreement

The undersigned represent that their statements in this application and Part II, if such Part II is required by the companies listed above ("the Companies"), are true and complete to the best of their knowledge and belief. It is agreed that:

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

(b) any prepayment made with this application will be subject to the provisions of the CONDITIONAL RECEIPT;

(c) if there is no prepayment made with this application, the policy will not take effect until:

(1) the first premium is paid during the lifetime of the proposed insured(s) and while his/her health and the facts and other conditions affecting their insurability remain as described in this application and Part II, if required; and

(2) the policy is delivered to the Owner;

(d) no one except the President, a Vice President, the Secretary, or an Assistant Secretary can make, alter or discharge contracts or waive any of the Companies' rights or requirements;

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

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

If applying for an indeterminate premium plan:

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

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

Fraud Notice

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

Dated at: _____
City State Month Day Year

_____
Print or Type Proposed Insured Name.

X _____
Signature of Proposed Insured.

_____
Print or Type Name of Other Proposed Insured.

X _____
Signature of Other Proposed Insured.

_____
Print or Type Owner if not Proposed Insured.

X _____
Signature of Owner if not Proposed Insured.

_____ _____
Print or Type 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

UNIFI®
Companies

CHECK ALL COMPANIES THAT APPLY: 1001

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HIV ANTIBODY TEST

Information Form For insurance Applicant

AIDS

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

The HIV Antibody Test

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

1. **Purpose**. This test is being run to determine whether you may have been infected with HIV. If you are infected, you are probably not insurable. This test is not a test for AIDS; AIDS can only be diagnosed by medical evaluation.

2. **Positive Test Results**. If you test positive, you should seek medical follow-up with your personal physician. If your test is positive, you may be infected with HIV, may develop AIDS, and may wish to consider further independent testing.

3. **Accuracy**. An HIV test will be considered positive only after confirmation by a laboratory procedure that the state health officer has determined to be highly accurate. Nonetheless, the HIV antibody test is not 100% accurate. Possible errors include:
   a. **False positives**: The test gives a positive result, even though you are not infected. This happens only rarely and is more common in persons who have not engaged in high risk behavior. Retesting should be done to help confirm the validity of a positive test.
   b. **False negatives**: The test gives a negative result, even though you are infected with HIV. This happens most commonly in recently infected persons; it takes at least 4-12 weeks for a positive test result to develop after a person is infected.

4. **Side Effects**. A positive test result may cause you significant anxiety. A positive test may result in uninsurability for life, health, or disability insurance policies you may apply for in the future. Although prohibited by law, discrimination in housing, employment, or public accommodations may result if your test results were to become known to others. A negative result may create a false sense of security.

5. **Disclosure of Results**. A positive test result will be disclosed to you. You may choose to have information about your HIV test results communicated to you through your physician or through the alternative testing site.

6. **Confidentiality**. Like all medical information, HIV test results are confidential. An insurer, insurance agent, or insurance-support organization is required to maintain the confidentiality of HIV test results. However, certain disclosures of your test results may occur, including those authorized by consent forms that you may have signed as part of your overall application. Your test results may be provided to the Medical Information Bureau, a national insurance data bank. Your insurance agent will provide you with additional written information about this subject at your request.

7. **Prevention**. Persons who have a history of high risk behavior should change these behaviors to prevent getting or giving AIDS, regardless of whether they are tested. Specific important changes in behavior include safe sex practices (including condom use for sexual contact with someone other than a long-term monogamous partner) and not sharing needles.

8. **Information**. For additional information about HIV and AIDS, the meaning of HIV test results, and the availability and location of HIV counseling services, you may call the New York AIDS Hotline at 1-800-541-AIDS.

Name of Physician or other person/entity _____

Informed Consent

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

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

1. An initial ELISA test will be done.
   a. If the initial ELISA test is positive, it will be repeated.
   b. If the initial ELISA test is negative, a negative finding will be reported to the Company.

2. If the initial ELISA test is positive, it will be repeated.
   a. If the second ELISA test is also positive, a Western Blot test will be performed to confirm the positive results of the two ELISA tests.
   b. If the second ELISA test is negative, a third ELISA test will be performed. If the third ELISA test is positive, a Western Blot test will be performed to confirm the previous positive results. If the third ELISA test is negative, a negative result will be reported to the Company.

3. Only if at least two ELISA tests and a Western Blot test are all positive will the result be reported as positive. All other results will be reported as negative to the Company.

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

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

(elect one) ☐ the Alternative Testing Site or ☐ my physician ☐ other

_____

(Name and address of attending physician)

_____

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

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

Dated at _____ Day _____ Month _____, year _____.

Witness _____ Proposed Insured/ _____
Agent (Signature) Parent or Guardian (Signature)

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

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

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

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

What can I do to help?

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

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

Become a volunteer.

Sponsor an AIDS fund-raising event or donate money.

Become a Red Cross HIV/AIDS instructor.

For more information, contact—

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

American Red Cross HIV/AIDS Programs

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

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

American Red Cross

Together, we can save a life

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A1597 (April 2004)

American Red Cross

Together, we can save a life

HIV AND AIDS

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

FACT: AIDS is caused by a virus called HIV.

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

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

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

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

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

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

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

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

You cannot get HIV from—

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

You cannot get HIV from using—

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

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

People become infected with HIV by:

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

FACT: You can protect yourself and others from HIV.

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

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

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

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

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

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

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

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

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

FACT: There are tests for HIV.

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

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

UNIFI® Companies

CHECK ALL COMPANIES THAT APPLY: 1150

☐ **Ameritas Life Insurance Corp. of New York**
P.O. Box 40888, Cincinnati, OH 45240
877-280-6110, Fax 513-595-2218
(Client Service Office)

☐ **The Union Central Life Insurance Company**
P.O. Box 40888, Cincinnati, OH 45240
800-319-6901, Fax 513-595-2218
(Client Service Office)

Electronic Fund Transfer (EFT)

Insured Name _____

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 (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.

POLICY NUMBER	PRINT NAME OF INSURED	PREMIUM PAYMENT	LOAN REPAYMENT	PREMIUM MGT. PAYMENT
		$	$	$
		$	$	$
		$	$	$
		$	$	$

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. (Does not apply to Union Central policies.) On Index UL Policies, the Withdrawal Date must be on the 25th of the month.

The Company(ies) 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

Name of Bank Account Holder: _____ _____
Print Name as shown on Bank Records — Bank Account Number

with _____ _____
Name of Bank and Branch Name, if any — Transit/ABA Routing Number

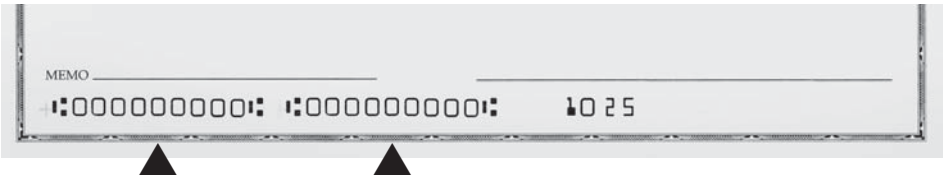
_____
City where account is maintained (include street address if available)

Requirements:

- Attach a copy of a Pre-printed Voided Check Here
  (Starter checks and Deposit Slips will not be accepted)

or

- Provide a letter from the bank indicating the ABA Routing Number, Account Number, and the Account Holder's Name for verification.



Transit/ABA Routing Number — **Account Number**

IT IS UNDERSTOOD THAT: Either or both of the above arrangements may be terminated by the Policy Owner or by the Company(ies) upon written notice. If the Bank Account Holder ("Payor") is other than the Policy Owner, the Company(ies) 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(ies) 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(ies), to pay and charge to my account checks, drafts or orders, whether by electronic or paper means, drawn on my account by the Company(ies) to its own order. This authorization will remain in effect until revoked by me in writing, and until the Company(ies) actually receives such notice I agree that the Company(ies) 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(ies) a replacement payment. If the Company(ies) 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.

➔

Date — Phone Number of Bank Account Holder — Signature of Bank Account Holder – as shown on Bank Records for the account to which this Authorization is applicable