Ameritas Life Insurance Corp. of New York
P.O. Box 40888, Cincinnati, OH 45240-0888
Telephone: 800-215-1096

PART 1 **APPLICATION FORM** Date of Transmittal _____

A. TO BE COMPLETED BY INSURED OR APPLICANT FOR BENEFIT

Insured _____ Policy No.(s)_____

Insured's Date of Birth _____ or SSN _____

Address _____ ZIP _____

List names of all physicians who have the treated insured's condition:

(1) Physician _____

Address _____

(2) Physician _____

Address _____

(3) Physician _____

Address _____

B. TO BE COMPLETED BY ASSIGNEE AND OWNER OF OTHER THAN INSURED

Owner's Name _____

Address_____

As assignee or owner of contractual rights under the policy(ies) shown on Page 1 of this form, I hereby consent to the payment of an Accelerated Benefit to the insured or to his or her authorized representative as directed.

(SIGNATURE ON PART 2 OF THIS FORM)

C. TO BE COMPLETED BY CREDITOR BENEFICIARY, IF ANY

Creditor Beneficiary's Name_____

Address_____ ZIP _____

As creditor beneficiary under the policy(ies) shown on Page 1, I hereby consent to the payment of an Accelerated Benefit to the insured or to his or her authorized representative as directed. If my creditor interest is to be satisfied from said payment, I have completed and submitted the necessary documents provided by Ameritas Life Insurance Corp. of New York.

(SIGNATURE ON PART 2 OF THIS FORM)

D TO BE COMPLETED BY SPOUSE AND/OR IRREVOCABLE BENEFICIARY, IF ANY

Spouse's Name _____ Date of Birth _____

-or-

Name of Irrevocable Beneficiary_____

Address _____ ZIP _____

As the insured's legal spouse and/or as the irrevocable beneficiary, I hereby consent to the payment of an Accelerated Benefit to the insured or to his or her authorized representative as directed.

(SIGNATURE ON PART 2 OF THIS FORM)

PART 2 DISCLOSURE STATEMENT

A. This accelerated benefit is NOT a long-term care policy. The amount this Rider pays may not be enough to cover nursing home or other bills.

B. **Receipt of accelerated death benefits may be taxable. Prior to applying for such benefits, you should seek assistance from a qualified tax advisor.**

C. **Receipt of accelerated death benefits MAY affect eligibility for public assistance programs such as medical assistance (Medicaid), aid to families with dependent children and supplemental security income. Prior to applying for accelerated death benefits, you should consult with the appropriate social service agency concerning how receipt will affect the eligibility of you and/or your spouse or dependents.**

D. The payment of an accelerated benefit MAY affect community property interest in certain jurisdictions. Therefore, we suggest that you contact your attorney.

E. We MAY charge a one-time administrative fee not to exceed .5% of the accelerated amount for processing a benefit under this rider. The fee will be applied to the lien and deducted from the death benefit at the time of death.

F. The payment of an accelerated benefit will be made only once in a lump sum. The payment of the accelerated benefit will decrease the death benefit by the following:

(1) The amount of the accelerated benefit paid; plus

(2) Any premiums paid us; plus

(3) Interest, as defined in the Interest provision of the rider, on the amount of the accelerated benefit and premiums paid by us; plus

(4) Any administrative fee.

G. We are prohibited from paying the accelerated benefit for a period of 14 days from the date on which you were furnished a numerical computation of the amount of the death benefit. This computation will be provided not later than five days after we receive your application.

H. No health care facility as defined in Section 20 of the New York Public Health Law can require any person to accelerate payment of a death benefit as a condition of admission to such health care facility or for not providing any care in such facility.

The applicant hereby applies to Ameritas Life Insurance Corp. of New York for payment of an Accelerated Benefit under the Rider made part of the policy(s) shown on Page 1. I have read and fully understand the Disclosure Statement shown on Part 2 of this form and I agree to the terms and conditions of the Accelerated Benefit Rider. This application is voluntary and without coercion on the part of any third party.

Please Note: This application must be completed and signed not more than 30 days after the date of transmittal by us.

Signature of:

Applicant _____ Date _____

Assignee/Owner _____ Date _____

Creditor/Beneficiary _____ Date _____

Spouse _____ Date _____

Irrevocable Beneficiary _____ Date _____