UNIFI®
Companies

Application for Insurance
Instructions and Checklist

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

Ameritas Life Insurance Corp.
P.O. Box 40888, Cincinnati, OH 45240
800-319-6901, 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)

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 fteen (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 ll in any blank information after the application has been signed.
5. Taxpayer Identi cation Number and Certi cation 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.

ALL PAGES MUST BE SENT WITH THE APPLICATION

Application Kit	Notice of Insurance Practices - *Give to Client*
	Personal Information - *Must Complete*
	Personal Information *(only as necessary)*
	Universal Life/Traditional Life Policy Details *(only as necessary)*
	Universal Life Policy Details *(only as necessary)*
	Universal Life/Traditional Life Policy Details *(only as necessary)*
	Life Financial Information - *Must Complete for Life Insur*ance
	Disability Income Policy Details *(only as necessary)*
	Disability Income Occupation and Financial Details *(Must Complete for DI)*
	Lifestyle Questionnaire *(Must Complete)*
	Health Questionnaire *(for each proposed insured)**
	Authorization *(Must Complete)*
	Agreement *(Must Complete)*
	Producer's Statement - *Must Complete*
	Conditional Receipt** *(only as necessary)*

*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 bene t 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.

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

UNIFI Companies℠

Application for Insurance

Notice of Insurance Information Practices

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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.

UNIFI Companies℠

Application for Insurance

Personal Information

CHECK ALL COMPANIES THAT APPLY:

☐ **Acacia Life Insurance Company**
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800-319-6901 Fax 513-595-2218
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800-319-6901 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)

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: _____

UNIFI Companies℠

Application for Insurance

Personal Information (continued)

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(Client Service Office)

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800-319-6901, Fax 513-595-2218
(Client Service Office)

1. Proposed Insured (Two):

a) Name: _____

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

d) Place of Birth: _____

e) Social Security/Tax ID No.: _____

f) Driver's License or other Government issued 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 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.: _____

UNIFI Companies℠

Universal Life
Policy Details

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

1. Universal Life :

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

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

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

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

e) Single Life Supplementary Benefits:
- ☐ Accelerated Benefits Rider *(include Disclosure Statement)*
- ☐ 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 Benefits Rider: $_____
- ☐ Waiver of Monthly Deductions Rider
- ☐ Other:_____

f) 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: $_____
- ☐ Total Disability Benefit Rider: *(Insured Two)*
  Amount: $_____
- ☐ Waiver of Monthly Deduction Rider *(Insured One)*
- ☐ Waiver of Monthly Deduction Rider *(Insured Two)*
- ☐ Other: _____

2. Premium:

a) Send Premium Notices to: ☐ Residence ☐ Business
☐ Owner ☐ Other: *(Specify relationship and address.)*
☐ Insured _____
_____

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

c) 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.)*
Amount: $ _____

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

UNIFI®
Companies

Ameritas Life Insurance Corp.
P.O. Box 40888 Cincinnati, OH 45240
800-319-6901, Fax 513-595-2218
(Client Service Office)

Universal Life/Traditional Life
Policy Details

1. Universal Life:

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

b) Death Bene t Option:
- ☐ Option A *(Specified Amount)*
- ☐ Option B *(Specified Amount plus Account Value)*
- ☐ Option C *(Return of Premium)*

c) Life Insurance Quali cation Test:
- ☐ GPT *(Guideline Premium Test)*
- ☐ CVAT *(Cash Value Accumulation Test)*

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

e) Single Life Supplementary Bene ts:
- ☐ Accelerated Bene t Rider *(include Disclosure Statement)*
- ☐ Accidental Death Bene t Rider: $_____
- ☐ Accounting Bene t Rider: $ _____
- ☐ Children's Insurance Rider: $ _____
- ☐ Guaranteed Insurability Rider: $_____
- ☐ Scheduled Increase Rider _____%
- ☐ Supplemental Coverage Rider: $ _____
- ☐ Term Insurance Rider: $ _____
- ☐ Total Disability Rider: $ _____
- ☐ Waiver of Monthly Deduction Rider
- ☐ Other: _____

f) Indexed UL Account Allocations:
____% Fixed Account: a current interest rate.
____% Capped Participation Account: a 100% participation rate on a limited percentage increase in the S & P Index.
____% Uncapped Participation Account: a lower participation rate on unlimited percentage increases in the S & P Index.
100 % Total

2. Whole Life:

a) Speci ed Amount: $ _____
Plan of Insurance:_____

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

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

2. Whole Life *(continued)*:

d) Supplementary Bene ts:
- ☐ Accelerated Bene ts Rider *(include Disclosure Statement)*
- ☐ Accidental Death Bene t Rider: $_____
- ☐ Children's Insurance Rider: $ _____
- ☐ Guaranteed Insurability Rider: $_____
- ☐ Level Term Rider: $_____
- ☐ One-Year Term Rider: $ _____
- ☐ Paid-Up Rider:
  - ☐ Annual Premium: $ _____
  - ☐ Single Premium: $ _____
- ☐ Term Paid-Up Rider (TPL): $ _____
- ☐ Total Disability Bene t Rider
- ☐ Waiver of Premium Rider
- ☐ Other: _____

3. Premium:

a) Send Premium Notices to: ☐ Residence ☐ Business
- ☐ Owner
- ☐ Insured
- ☐ Other: *(Specify relationship and address)*

_____
_____

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

c) 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.)*
Amount: $ _____

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

UNIFI Companies℠

Universal Life / Traditional Life
Policy Details

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

1. Universal Life :

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

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

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

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

e) Single Life Supplementary Benefits:
- ☐ Waiver of Monthly Deductions Rider
- ☐ Total Disability Benefits Rider: $ _____
- ☐ Accidental Death Benefit Rider: $ _____
- ☐ Guaranteed Insurability Rider: $ _____
- ☐ Supplemental Coverage Rider: $ _____
- ☐ Accounting Benefit Rider: $ _____
- ☐ Other Insured Term Rider: $ _____
- ☐ Children's Insurance Rider: $ _____
- ☐ Accelerated Benefits Rider *(include Disclosure Statement)*
- ☐ Scheduled Increase Rider: _____%
- ☐ Other: _____

f) Survivorship Supplementary Benefits:
- ☐ Policy Split Rider
- ☐ Estate Protection Rider
- ☐ Term Insurance Rider
  - ☐ To Age: _____ ☐ Amount: $ _____
- ☐ Scheduled Increase Option Rider: _____%
- ☐ Maturity Extension
- ☐ Waiver of Monthly Deductions Rider
- ☐ Cost of Living Rider
- ☐ Other: _____

g) Indexed UL Account Allocations
_____ % Fixed Account: a current interest rate.
_____ % Capped Participation Account: a 100% participation rate on a limited percentage increase in the S & P Index.
_____ % Uncapped Participation Account: a lower participation rate on unlimited percentage increases in the S & P Index.
100 % Total

2. Term Life:

a) Specified Amount: $ _____

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

c) Supplementary Benefits:
- ☐ Waiver of Premium Rider
- ☐ Accidental Death Benefit Rider: $ _____
- ☐ Accelerated Benefits Rider *(include Disclosure Statement)*
- ☐ Children's Insurance Rider: $ _____
- ☐ Other: _____

3. Whole Life:

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

b) Dividend Option:
- ☐ Paid-up additions
- ☐ Cash
- ☐ Accumulate at Interest
- ☐ Reduce premium *(not on monthly modes)*
- ☐ One-year term
- ☐ Other: _____

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

d) Supplementary Benefits:
- ☐ Waiver of Premium Rider
- ☐ Total Disability Benefit Rider
- ☐ Accidental Death Benefit Rider: $ _____
- ☐ Term Paid-up Rider *(TPL)*: $ _____
- ☐ Paid-Up Rider:
  - Annual Premium: $ _____
  - Single Premium: $ _____
- ☐ One Year Term Rider: $ _____
- ☐ Future Purchase Option Rider: $ _____
- ☐ Accelerated Benefits Rider *(include Disclosure Statement)*
- ☐ Estate Protection Rider
- ☐ Children's Insurance Rider: $ _____
- ☐ Other: _____

4. Premium:

a) Send Premium Notices to: ☐ Residence ☐ Business
☐ Owner ☐ Other: *(Specify relationship and address.)*
☐ Insured _____

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

c) 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.)*
Amount: $ _____

UNIFI Companies℠

Universal Life / Traditional Life

Financial Information

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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. 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:

3. 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.)*

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.)*

5. 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: $

6. Source of Premiums: *(Check one or more.)*

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

7. 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 / key employees being insured? ☐ Yes ☐ No *(If "Yes," give details.)*

UNIFI®
Companies

Disability Income
Policy Details

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

1. Individual Disability Income Insurance:

a) Contract Type
☐ Non Cancelable (U4501NC)
☐ Guaranteed Renewable (U4502GR)

b) De nition of Disability
☐ Own Occ for bene t period (OO)
☐ Own Occ and Not Working for bene t period (NW)
☐ 60 month Own Occ and Not Working thereafter (ON)

c) Base Monthly Bene t: $ _____

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

e) Bene t 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)*: _____
Bene t 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 bene t is payable during the elimination period of any disability? ☐ Yes ☐ No

2. Business Overhead Expense:

a) Base Monthly Bene t: $ _____

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

c) Bene t 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 bene t is payable during the elimination (waiting) 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 ☐ Electronic Funds Transfer (complete EFT form)
☐ Semi-Annual ☐ Salary Allotment/List Bill
☐ Quarterly List bill number _____
☐ Step Rate ☐ Other:_____

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

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

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

4. Business Ownership:

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

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

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

5. Occupation / Employment:

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

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

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

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

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

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

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

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

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

UNIFI Companies℠

Disability Income

Occupation and Financial Details

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

1. Financial Information:

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

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

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

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

d) If yes, what is the annual contribution? $

e) Net Worth: *(If net worth exceeds $4,000,000, itemize below.)*
Cash, savings, stocks, bonds: $
Personal residence: $
Other real estate: $
Business interest: $
Personal Property: $
Other *(describe)*: $

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

2. Insurance Details:

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

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

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

3. Existing Insurance *(Replacement)*:

Will any disability insurance with Union Central or any other insurance company be replaced, reduced or changed if the insurance now applied for is issued? ☐ Yes ☐ No *(If "Yes," give details.)*
Company:
Policy Number:
Amount to be replaced: $
Other changes:

4. Insurance Producer's Replacement Statement:

To the best of your knowledge, does the policy applied for involve replacement, in whole or in part, of any existing life insurance, annuity, disability income or overhead expense insurance, or any other accident and sickness insurance? ☐ Yes ☐ No *(If "Yes," give details.)*
Company: Policy No.:

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

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

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

c) List that portion of monthly overhead expenses for which you are responsible: *(Exclude: payments or salaries paid to you, employees or partners in your profession.)*
Rent/Lease: $
Utilities: $
Telephone: $
Depreciation: $
Liability Insurance: $
Property Taxes: $
Salaries: $
Mortgage Interest: $
Payroll Taxes: $
Employee Benefits: $
Other: $

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

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Application for Insurance

Lifestyle Questionnaire

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

Ameritas Life Insurance Corp.
P.O. Box 40888, Cincinnati, OH 45240
800-319-6901 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)

Lifestyle Questions: *(Please provide details for "Yes" answers.)*

Has any person proposed for coverage:

1. Used tobacco or nicotine products in any form within the last five years? *(In Details, provide dates and type: cigarettes, cigars, cigarillos, a pipe, chewing tobacco, nicotine patches, gum, etc.)* ☐ Yes ☐ No
2. Ever applied for insurance or reinstatement which has been: declined, postponed, rated, modified; or had any such insurance canceled or a renewal premium refused? (In Details, provide date, reason, and company name.) ☐ Yes ☐ No
3. Ever received or claimed: indemnity, benefits, or a payment for any injury, sickness or impaired condition? ☐ Yes ☐ No
4. 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 traveling outside the U.S. or Canada or residing outside of the U.S.? *(If "Yes," complete Foreign Travel Questionnaire.)* ☐ Yes ☐ No
8. Belong to or intend joining: any active or reserve military, naval, or aeronautic organization? *(If "Yes," complete Military Service Questionnaire.)* ☐ Yes ☐ No
9. Engaged in or plan to engage in any form of the following: *(If "Yes," check all boxes below that apply and complete appropriate form(s).)* ☐ Yes ☐ No

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

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

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

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Application for Insurance

Health Questionnaire

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

Ameritas Life Insurance Corp.
P.O. Box 40888, Cincinnati, OH 45240
800-319-6901 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)

Name of Proposed Insured: _____

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

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

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

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

For each "Yes" answer, give details. *(Identify: question number, diagnoses, dates, duration, names and addresses of all attending physicians and medical facilities. Attach additional Health Questionaire page, if needed.)*

UNIFI Companies℠

Application for Insurance

Health Questionnaire

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

Ameritas Life Insurance Corp.
P.O. Box 40888, Cincinnati, OH 45240
800-319-6901 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)

Name of Proposed Insured: _____

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

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

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

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

For each "Yes" answer, give details. *(Identify: question number, diagnoses, dates, duration, names and addresses of all attending physicians and medical facilities. Attach additional Health Questionaire page, if needed.)*

UNIFI Companies℠

Application for Insurance

Authorization

Acacia Life Insurance Company
P.O. Box 40888, Cincinnati, OH 45240
800-319-6901 Fax 513-595-2218
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P.O. Box 40888, Cincinnati, OH 45240
800-319-6901 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)

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, or tobacco, HIV, AIDS and sexually transmitted diseases, prescription drug records, financial status, education records, 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 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 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

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

Agreement

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

(a) the only statements to be considered as the basis of the policy are those contained in the application or in any amendment to the application;
(b) any prepayment made with this application will be subject to the provisions of the CONDITIONAL RECEIPT;
(c) if there is no prepayment made with this application, the policy will not take effect until:
(1) the first premium is paid during the lifetime of the proposed insured(s) and while his/her health and the facts and other conditions affecting their insurability remain as described in this application and Part II, if required; and
(2) the policy is delivered to the Owner;
(d) no one except the President, a Vice President, the Secretary, or an Assistant Secretary can make, alter or discharge contracts or waive any of the Companies' rights or requirements; 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.

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.

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.

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

Application for Insurance

Producer's Statement

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

Ameritas Life Insurance Corp.
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800-319-6901, 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
(Customer Service Office)

1. Background Information

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

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

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

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

Competing Company: _____

3. Did you receive Home Office Assistance? ☐ Yes ☐ No
(If yes, please provide details in Producer Remarks.)

4. Life Insurance Information

a) If proposed insured is married, indicate amount of life insurance in force on spouse: $_____

b) If proposed insured is under 18 years of age:
Amount of insurance in force on life of parents:

_____

Estimate parents' worth: _____

Estimate parents' income: _____

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

Purpose of Insurance:

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

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

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

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

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

_____

6. Disability Income Insurance Information

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

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

Producer Remarks:

_____

_____

7. Producer's Certification *(Must be Signed and Dated)*

I Certify that:

- I have reasonable grounds to believe the purchase of the policy applied for is suitable for the policy owner based on the information furnished by the proposed insured and/or policy owner in this application.
- A current prospectus(es) was (were) delivered to the proposed insured. (Applicable to Variable Products Only.)
- All of the sales materials used have been approved in advance by the Home Office.
- I am familiar with UNIFI Companies' 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: _____

UNIFI®
Companies

Application for Insurance
Conditional Receipt

Acacia Life Insurance Company
P.O. Box 81889, Lincoln, NE 68501
800-745-1112, Fax 402-467-7335
(Client Service Office)

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

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

DO NOT DETACH UNLESS PREMIUM PAYMENT, WHICH INCLUDES AUTHORIZATION FOR ELECTRONIC FUND TRANSFER (EFT), IS MADE WHEN APPLICATION IS DATED AND SIGNED. DO NOT USE IF LIFE INSURANCE APPLIED FOR IS OVER $1,000,000. DO NOT USE IF DISABILITY INCOME OR DISABILITY OVERHEAD EXPENSE IS OVER $8,000 PER MONTH. 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.

Terms and Conditions

All of the terms and conditions of this receipt must be ful lled for insurance to be in effect on the "coverage date" or no insurance will be in effect under this receipt. The "coverage date" is the date of this application or Part II or medical examination or other test required by published rules of the companies listed above ("the Companies") used when considering the bene ts applied for, whichever date is latest.

1. Premium Payment

For Adjustable Life insurance, the premium payment taken with this application must be equal to or greater than the full initial premium. For any other life insurance, or Disability Income insurance, the premium taken with this application must be equal to the full rst premium for the mode of premium and bene ts applied for.

2. Insurability

As of the "coverage date," the Companies' Underwriting Officer must nd each person proposed for insurance to be an acceptable risk at standard premium rates for the bene ts applied for without an exclusion or restrictive endorsement.

3. Conditional Insurance

If all of the conditions of this receipt are met, insurance under this receipt will be provided from the "coverage date" to the date the policy is delivered, subject to maximum amount limitations set out below.

4. a) Maximum Amount *(applicable to life insurance only)*

Any liability of the Companies under this and any other receipts may not exceed the lesser of: (a) the amount applied for in this application, or in the case of Adjustable Life insurance-the initial speci ed amount applied for; or (b) $1,000,000 of insurance and $100,000 of accidental death bene ts.

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

Any liability of the Companies under this and any other receipts may not exceed the lesser of: (a) the amount applied for in this application; or (b) $8,000 per month of Disability Income or Disability Overhead Expense.

5. Termination of Conditional Insurance

If insurance is provided under this receipt, it will terminate when the policy(ies) is/are delivered. If the application is declined, the premium paid will be refunded and there will have been no coverage provided under this receipt.

6. Suicide

If any person proposed for insurance commits suicide, the Companies' liability under this receipt will be limited to a refund of the premium payment acknowledged above.

NOTICE TO APPLICANT -
PLEASE READ THIS RECEIPT CAREFULLY.

No insurance is provided under this conditional receipt unless all terms and conditions of this receipt are met. This receipt is void if the payment is made by a check or draft that is not honored when presented for payment. Also void are any modi cations made to the conditions of this receipt. All premium checks must be made payable to the appropriate Company. Do not make checks payable to the insurance producer or leave checks blank.

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 Insurance Producer

CHECK ALL COMPANIES THAT APPLY:

UNIFI® Companies

☐ **Acacia Life Insurance Company**
P.O. Box 81889, Lincoln, NE 68501
800-745-1112, Fax 402-467-7335
(Client Service Department)

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

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

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

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 local health department or the State Department of Health, and if the Insurer is a member of the Medical Information Bureau (MIB, Inc.), 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 the MIB, Inc. Other test results may be reported to the MIB, Inc. 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 your local Health Department 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 Health Department reporting purposes:

Name and address of designated physician/health care provider:

_____

_____

_____

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

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	State of Residence
	_____
	Date

UNIFI® Companies

CHECK ALL COMPANIES THAT APPLY: 1150

☐ **Acacia Life Insurance Company**
P.O. Box 81889, Lincoln, NE 68501
800-745-1112, Fax 402-467-7335
(Client Service Office)

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

☐ **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) • For Initial Premium and/or Automatic Monthly Payments

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

* 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)

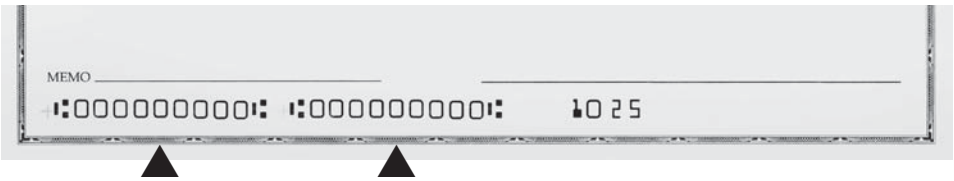
_____
(Address of Bank or Branch where account is maintained)

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)