Application for Individual Life Insurance

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

I. PROPOSED INSURED/OWNER/PAYOR:

1. Name (First, Middle, Last):	2. Date of Birth:	3. Social Security or Tax ID Number:
4. [Physical] Address [(Number and Street)]:		
5. City:	6. State:	7. Zip Code:
8. E-mail Address:		
9. [Cell] Phone Number:	10. Birth State:	11. Birth Country, if not born in US:
12. Gender: □ Male □ Female		
13. Do you have a driver's license? □ Yes □ No [Driver's License number:_____ Issue State:_____]		
14. Are you a US citizen or permanent resident? □ Yes □ No		
15. Height: Weight: [Has your weight increased or decreased by more than [15] pounds in the past year? □ Yes □ No]		
[16. Attending Physician Name, address, email, phone number:]		

II. COVERAGE APPLIED FOR:

1. Level Premium Term: □ 10 Year Term □ 15 Year Term □ 20 Year Term □ 30 Year Term	2. Amount of Insurance:
3. [Riders: Terminal Illness Accelerated Benefit Rider]	

III. PRIMARY BENEFICIARY: Beneficiary will be the Estate of the Insured unless another individual is designated in this section. See additional information section for all beneficiary designations.

1. Name (First, Middle, Last):	2. Date of Birth:	3. [Social Security or Tax ID Number:]
4. [Current Mailing Address (Number and Street):]		
5. [City:]	6. [State:]	7. [Zip Code:]
8. [E-mail Address:]		
9. Percentage of Benefit:	10: Relationship to the Insured: □ Estate □ Spouse [or Civil Union Partner] □ Child □ Parent □ Fiancé □ [Common Law Spouse or] Domestic Partner □ Other (please provide relationship)_____	

IV. UNDERWRITING QUESTIONS:

1. Are you permanently disabled, receiving disability benefits [including Social Security disability benefits], or currently confined to a hospital or assisted living facility [not including short term disability due to childbirth]? □ Yes □ No

2. In the past 90 days, have you been admitted, or advised by a medical professional to be admitted, to a hospital or other licensed health care facility, had surgery performed or recommended [other than minor, elective orthopedic procedures, fully recovered c-section, fully recovered tonsillectomy, fully recovered appendectomy or dental surgery], or been advised to have any diagnostic test except those tests related to the HIV (AIDS virus) that was not completed or results not yet received? □ Yes □ No

3. Within the past [10] years, have you been diagnosed, treated or given medical advice from a medical professional for:

- **Cancer:** [Cancer (other than basal cell or squamous carcinoma), including leukemia, lymphoma, melanoma, brain tumor, or any malignant tumor]
- **Chronic lung disease or disorder:** [Including chronic bronchitis, emphysema, sarcoidosis, cystic fibrosis, untreated sleep apnea (not to include mild asthma)]
- **Diabetes:** [Diagnosed before age [40] and treated with insulin]
- **Heart or vascular disease or disorder:** [Including coronary artery or heart disease, heart attack, angina, congestive heart failure, enlarged heart, heart surgery, pulmonary embolism, peripheral vascular disease or carotid artery disease, or use of a pacemaker or defibrillator] [Excluding controlled hypertension and controlled hyperlipidemia]
- **HIV/AIDS**
- **Kidney disease or disorder:** [Excluding kidney stones]
- **Liver disease or disorder:** [Including cirrhosis and hepatitis (other than acute or recovered type A)]
- **Mental health disease or disorder:** [Including schizophrenia, [bipolar,] personality disorders, attempted suicide or hospitalization within the last 5 years for any mental health disorder or disease (not to include mild anxiety[, mild depression, ADD, or ADHD])]
- **Nervous system disease or disorder:** [Including multiple sclerosis, dementia, cognitive impairment, Parkinson's, ALS/Lou Gehrig's, paralysis, muscular dystrophy, stroke/TIA, or other neurological disease or brain disorder]
- **Organ transplant recipient, Crohn's disease or Ulcerative Colitis, Pancreatitis, Lupus/SLE or Scleroderma**

□ Yes □ None of the above

4. Within the past [10] years, have you:

- Been advised to, or received treatment or counseling by a medical professional, to limit or discontinue the use of alcohol, non-prescribed or prescribed drugs, or participated in a support group for alcohol or drug use
- Used, or tested positive by a medical professional for cocaine, heroin, non-prescribed amphetamines or hallucinogens

□ Yes □ None of the above

5. In the past 5 years, have you plead guilty to or been convicted of driving while impaired or reckless driving, or is your license currently suspended or revoked? □ Yes □ No

6. In the past 10 years, have you plead guilty to or been convicted of a felony, or are you currently on probation, parole or have pending felony charges? □ Yes □ No

7. [In the last [30 days], have you been diagnosed with, been treated for, [or sought testing or consultation,] or do you intend to seek testing or consultation with a medical professional for Coronavirus including COVID-19, or for fever, or cough, or shortness of breath? □ Yes □ No]

8. [Have you ever made any flights, or do you plan to within the next 2 years, as a non-commercial pilot, student pilot or crew member? □ Yes □ No]

9. [Have you ever used tobacco or nicotine products in any form in the last [5 years]? □ Yes □ No]

V. INSURANCE HISTORY: Please refer to the Additional Information Section for details regarding your affirmative responses.

1. Within the past [5] years have you had an application for life insurance declined[, postponed, rated (charged extra premium) or offered with a reduced amount]? □ Yes □ No
2. Do you have any existing life insurance policies or annuity contracts? □ Yes □ No
3. Do you have any agreements in place to assign/sell this policy? □ Yes □ No

VI. [SECONDARY ADDRESSEE:]

[Would you like a second person to receive copies of billing related correspondence? □ Yes □ No]

Declarations

[FOR EFT PAYMENT ELECTION: AUTHORIZATION FOR ELECTRONIC FUNDS TRANSFER - By signing this application, I authorize the Company to initiate a monthly, quarterly, or annual withdrawal from the specified account of the financial institution indicated, for the purpose of meeting premium payment obligations.

I understand:

(1) No premium is considered paid until each debit is accepted by the financial institution.

(2) Any debit not honored may be subject to a return fee from the financial institution.

(3) For any debit not honored, the Company may attempt to debit the account again up to three days later for the amount due.
(4) The Company will not incur liability as a result of a debit that is not honored by the financial institution.

(5) The insured/owner/payor or the Company may terminate this agreement at any time by written notification from one party to the other party.]

FOR CREDIT CARD ELECTION: AUTHORIZATION FOR CREDIT CARD PAYMENT - By signing this application, I authorize a monthly charge to the credit card provided for the purpose of meeting premium payment obligations. I agree not to contest these charges upon approval of this credit card transaction.

By signing below, I represent that my statements in this application are required by the Company, are true and complete to the best of my 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) 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
   (2) the policy is delivered to the Owner;
c) no one except the President, a Vice President, the Secretary, or an Assistant Secretary can make, alter or discharge contracts or waive the Company's rights or requirements; and
d) this application was signed and dated in the state indicated.

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

_____ Signed in _____ on _____

Proposed Insured/Owner | City/State | Date (mm/dd/yyyy)

[Additional Information (Ameritas Life Insurance Corp. Application, continued)

Name: [Insured Name], Policy Number: [00000000000], Ethos Id: [XXXXXX]

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

_____ Signed in _____ on _____
Proposed Insured/Owner City/State Date (mm/dd/yyyy)]