UNIFI Companies℠

Application for Insurance

Instructions and Checklist

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

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.

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

				Included?	
Application Kit	Provide to Insured	UN 2550 NI	Notice of Insurance Practices	☐ Yes	N/A
	Always Submit	UN 2550 PI-A	Personal Information	☐ Yes	N/A
	Submit as Required	UN 2550 PI-B	Personal Information (only as necessary)	☐ Yes	☐ No
		UN 2550 LIFE AC	Acacia Universal Life/Traditional Life Policy Details	☐ Yes	☐ No
		UN 2550 LIFE ALIC	Ameritas Universal Life Policy Details	☐ Yes	☐ No
		UN 2550 LIFE UC	Union Central Universal Life/Traditional Life Policy Details	☐ Yes	☐ No
		or			
		UN 2550 PD-V ALIC	Ameritas Variable Universal Life Policy Details	☐ Yes	☐ No
		UN 2550 IA-V ALIC	Investment Advisory Agreement	☐ Yes	☐ No
		UN 2550 AP ALIC-H	Protector *h*VUL Allocation of Premiums	☐ Yes	☐ No
		UN 2550 AP ALIC EP	Excel Performance VUL Allocation of Premiums	☐ Yes	☐ No
		UN 2550 FI	Life Financial Information	☐ Yes	☐ No
		or			
		UN 2550 DI	Disability Income Policy Details	☐ Yes	☐ No
		UN 2550 DI FI	Disability Income Occupation and Financial Details	☐ Yes	☐ No
		UN 2550 LQ	Lifestyle Questionnaire	☐ Yes	☐ No
		UN 2550 HQ	Health Questionnaire (for each proposed insured)*	☐ Yes	☐ No
	Always Submit	UN 2550 AU	Authorization	☐ Yes	N/A
		UN 2550 AG	Agreement	☐ Yes	N/A
		UN 2550 PS	Producer's Statement	☐ Yes	N/A
		UN 2550 CR	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.

Securities offered through affiliate Ameritas Investment Corp., member NASD/SIPC.

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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:

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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

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

Disability Income
Policy Details

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

1. Individual Disability Income Insurance:

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

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

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)*: _____
☐ Future Increase Option Rider: Amount: $ _____
☐ Automatic Increase Rider

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:

a) Base Monthly Benefit: $ _____

b) Elimination (Waiting) 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 (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.)
_____
_____

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Disability Income

Occupation and Financial Details

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

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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Lifestyle Questionnaire

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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 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

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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 convicted 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 nonpresciption)* 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, UN 2550 HQ, if needed.)*

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Authorization

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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, 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.)

UNIFI Companies℠

Application for Insurance

Agreement

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

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 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 513-595-2532
(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 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

DO NOT DETACH UNLESS PREMIUM PAYMENT 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 fulfilled 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 benefits 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 first premium for the mode of premium and benefits applied for.

2. Insurability

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

3. 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 specified amount applied for; or (b) $1,000,000 of insurance and $100,000 of accidental death benefits.

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 modifications 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,

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**
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800-745-1112, Fax 402-467-7335
(Client Service Office)

☐ **Ameritas Life Insurance Corp.**
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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 Form

This Plan shall apply to the following policy(ies):

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

***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)**

Effective Month to begin automatic withdrawals: _____ Withdrawal Date: _____

FOR THE PURPOSE OF:

(1) ☐ Collecting monthly premium. If new account, an application dated _____ , _____
(Name of Proposed Insured or Annuitant)

(2) ☐ Collecting monthly policy loan principal and interest payments of $ _____ .
Where more than one policy loan is involved, each payment will be applied proportionately to each policy.

THE UNIFI COMPANIES, 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 account of:

Name of Bank Depositor: _____ _____
(Print Name as shown on Bank Records) (Depositor's Checking Account Number, if any)

with _____ _____
(Name of Bank and Branch Name, if any) (Transit Number) (Routing Symbol)

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

A VOIDED CHECK IS REQUIRED FOR ACCURATE ENCODING OF ACCOUNT INFORMATION
STAPLE CHECK HERE

Please Do Not Submit Starter Checks or Deposit Slips

IT IS UNDERSTOOD THAT: Either or both of the above arrangements may be terminated by the policy owner or by the Company upon written notice. If the Bank Depositor is other than the policy owner, the Company will terminate either or both of the arrangements upon written request of such Bank Depositor. Should the Premiums cease to be paid by Electronic Payment, the Company will accept payment of quarterly, semiannual or annual premium payments at the Company's published rates in effect as of the date of the policy.

For Policies Earning Dividends: Dividends cannot be used to apply on Electronic Payment premiums. If dividends are currently being used to reduce premiums, please submit a dividend change form (UN 3379 B).

As a convenience to me, I hereby request and authorize you to pay and charge to my Account checks, drafts or orders, whether by electronic or paper means, drawn on my account by THE UNIFI COMPANIES to it own order. This authorization will remain in effect until revoked by me in writing, and until you actually receive such notice I agree that you shall be fully protected in honoring any such order.

I agree that your treatment of each such item, and your rights in respect to it, shall be the same as if it were signed personally by me. I further agree that if any such check, draft or order be dishonored, whether with or without cause, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

The bank shall be under no obligation to furnish me 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) (Signature of Bank Depositor - as shown on Bank Records for the account to which this Authorization is applicable)

CHECK ALL COMPANIES THAT APPLY:

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800-319-6901, Fax 513-595-2352

Notice and Consent Form for AIDS Virus (HIV) Antibody/Antigen Testing

Examiner (Name) _____

(Address) _____

Acquired Immunodeficiency Syndrome (AIDS) is a life-threatening disorder of the immune system. It is caused by a virus called Human Immunodeficiency Virus (HIV). The virus is spread by sexual contact with an infected person, by exposure to infected blood (as in needle sharing during intravenous drug use or, rarely, as a result of a blood transfusion), or from an infected mother to her newborn infant.

To determine your insurability, the insurer named above (the Insurer) has requested that you provide a sample of your blood for testing and analysis. All tests will be performed by a licensed laboratory.

Unless precluded by law, tests will be performed to determine the presence of HIV antibodies or antigens. 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 reliable. Should you desire more information about the test of HIV infection before providing a blood sample, you may wish to consult with your physician or your local health department. If you are at high risk of HIV infection, you may want to be counseled and tested by your physician or at a free/low cost local test site. Your local health department can provide you with information as to the location of these sites.

All tests 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 such as its affiliates, reinsurers, employees or contractors, but not to agents and brokers.

If the Insurer is a member of the Medical Information Bureau (MIB, Inc.), and if the test results for HIV antibodies/antigens are other than normal, the Insurer will report to the MIB, Inc. a generic code which signifies only a non-specific blood test abnormality. If your HIV test is normal, no report will be made about it to the MIB, Inc.

The organizations described in the last two paragraphs 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 will contact you. 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.

You are urged, at this time, to designate the physician or other health care provider to whom the HIV test results may be disclosed by the Insurer in the event the results are other than normal.

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

I authorize the disclosure of any HIV test results which are other than normal to the following physician or health care provider:

Name _____

Address _____

City_____ State_____Zip Code _____

I have read and understand this Notice of Consent for AIDS Virus (HIV) Antibody/Antigen Testing. I voluntarily consent to the withdrawal of blood from me by needle, the testing of that blood, and the disclosure of the test results as described above.

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

_____ _____

Proposed Insured Date of Birth

_____ _____

Signature of Proposed Insured or Parent/Guardian Date State of Residence

UNIFI®
Companies

Part II – Non-Medical

CHECK ALL COMPANIES THAT APPLY:

☐ **Acacia Life Insurance Company**
P.O. Box 81889, Lincoln, NE 68501
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(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 513-595-2218
(Client Service Department)

Proposed Insured: _____ Birth Date: _____
First Name Middle Name Last Name Month Day Year

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 (excluding HIV)? . . . . . ☐ Yes ☐ No
   b. Been advised by a licensed medical professional to have any diagnostic test (excluding HIV), 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 convicted 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 physician:
   _____
   _____
   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 sheet if needed.)

I, the undersigned, declare that the answers to the foregoing questions relate to the proposed insured, are complete and true as written to the best of my knowledge and belief, are correctly recorded, are made for the purpose of obtaining the insurance and any supplemental benefit applied for and shall form a part of any contract issued by the Companies on this application and the initial application (UN 2550, et al.)

CT RESIDENTS: 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 during the contestability period.

Dated at: _____
City State Month Day Year

Witness: _____
(Must be Agent)

Signature of Proposed Insured: _____

Signature of Parent or Guardian: _____
If Proposed Insured is under age 18

UNIFI®
Companies

Application for Insurance
Authorization

Acacia Life Insurance Company
P.O. Box 81889, Lincoln, NE 68501
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The Union Central Life Insurance Company
P.O. Box 40888, Cincinnati, OH 45240
800-319-6901, Fax 513-595-2218
(Client Service Department)

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.