



Companies

Application for Insurance

Instructions and Checklist

First Ameritas Life Insurance Corp. of New York

P.O. Box 40888, Cincinnati, OH 45240
877-280-6110, Fax 513-595-2352
(Client Service Office)

The Union Central Life Insurance Company

P.O. Box 40888, Cincinnati, OH 45240
800-319-6901, Fax 513-595-2352
(Client Service Office)

1. The Notice of Insurance Information Practices must be given to the client prior to completion of the application.
2. The proposed insured, spouse, and applicant, if any, must sign the form where indicated.
3. We will not accept applications on minors younger than fifteen (15) days old. A parent or guardian must give consent to any applicant under age 18.
4. ALL questions must be answered. Changes to answers must be initialed and dated by the proposed insured and the applicant, if the applicant is not the proposed insured. Do not use white out to change any answers, or fill in any blank information after the application has been signed.
5. Taxpayer Identification Number and Certification form must be completed and returned to the Home Office.
6. If a life insurance or annuity contract is being replaced, you must follow appropriate replacement procedures.

TRADITIONAL & UNIVERSAL LIFE **VARIABLE UNIVERSAL LIFE** **DISABILITY INCOME** **EZ APP**
Included?

Application Kit	Provide to Insured	UN 2550 NI NY	Notice of Insurance Practices	<input type="checkbox"/> Yes	N/A
	Always Submit	UN 2550 PI NY	Personal Information for FA Policies	<input type="checkbox"/> Yes	N/A
		UN 2550 PI-A NY	Personal Information for UC Term, VUL and DI policies	<input type="checkbox"/> Yes	N/A
	Submit as Required	UN 2550 PI-B NY	Personal Information (only as necessary) for UC Term, VUL and DI policies	<input type="checkbox"/> Yes	<input type="checkbox"/> No
		UN 2550 PD NY	Universal Life/Traditional Life Policy Details	<input type="checkbox"/> Yes	<input type="checkbox"/> No
		UN 2550 LIFE UC NY	Universal Life/Traditional Life Policy Details (Term Only)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
		or			
		UN 2550 PD-V UC NY	Variable Universal Life Policy Details	<input type="checkbox"/> Yes	<input type="checkbox"/> No
		UN 2550 IA-V UC NY	Investment Advisory Agreement	<input type="checkbox"/> Yes	<input type="checkbox"/> No
		UN 2550 AP UC EP NY	Excel Performance Allocation of Premiums	<input type="checkbox"/> Yes	<input type="checkbox"/> No
		UN 2550 FI NY	Life Financial Information	<input type="checkbox"/> Yes	<input type="checkbox"/> No
		UN 2550 SI NY	Suitability Information (2 pages)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
		or			
		UN 2550 DI NY	Disability Income Policy Details	<input type="checkbox"/> Yes	<input type="checkbox"/> No
		UN 2550 DI FI NY	Disability Income Occupation and Financial Details	<input type="checkbox"/> Yes	<input type="checkbox"/> No
		UN 2550 LQ NY	Lifestyle Questionnaire	<input type="checkbox"/> Yes	<input type="checkbox"/> No
		UN 2550 HQ NY	Health Questionnaire (for each proposed insured)*	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Always Submit	UN 2550 AU NY	Authorization	<input type="checkbox"/> Yes	N/A
		UN 2550 AG NY	Agreement	<input type="checkbox"/> Yes	N/A
		UN 2550 PS NY	Producer's Statement	<input type="checkbox"/> Yes	N/A
UN 2550 CR NY		Conditional Receipt**	<input type="checkbox"/> 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 FINRA and SIPC.

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.

CHECK THE COMPANIES THAT APPLY:

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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: _____

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Disability Income

Policy Details

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
 - 180 365 730
- e) Benefit Period:
 - 1 Year 2 Years 5 Years 10 Years
 - To Age 65 To Age 67 To Age 70
- f) Riders:
 - Enhanced Residual Disability Rider
 - Basic Residual Disability Rider
 - Cost of Living Adjustment Rider – 6% Compound
 - Cost of Living Adjustment Rider – 3% Simple
 - Social Insurance Substitute Rider:
 - Amount: \$ _____ Elimination Period (Days): _____
 - Catastrophic Disability Rider:
 - Amount: \$ _____ Elimination Period (Days): _____
 - Benefit Period (Years): _____
 - Future Increase Option Rider: Amount: \$ _____
 - Automatic Increase Rider
 - Other: _____
- g) Do you understand and agree that under the terms of the Individual Disability Income policy applied for, no monthly benefit is payable during the elimination period of any disability? Yes No

2. Business Overhead Expense:

- 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 Step Rate List bill number _____
 - Other: _____
- d) Association Discount: Yes No (If "Yes," give IPN.)
Association IPN: _____
- e) Has any premium been given in connection with this application? Yes No
(If "Yes," state amount paid for which conditional receipt has been given, the terms of which are hereby agreed to.)
Individual Disability Income: \$ _____
Business Overhead Expense: \$ _____
Total: \$ _____

4. Business Ownership:

- a) Do you have any ownership in the business where you work? Yes No If "Yes," what percent do you own? _____%
- b) If yes, what type of business is it?
 - C-Corp S-Corp LLP
 - LLC Partnership Sole Proprietor
 - Other: _____
- c) If yes, how many other owners or partners are there? _____

5. Occupation / Employment:

- a) How many total employees are there in the business where you work? _____
- b) How long have you been employed at the business where you work? _____
- c) How many hours per week do you work in your primary occupation? _____
- d) How long have you worked in your primary occupation? _____
- e) Do you have any other occupations not listed elsewhere on this application? Yes No
(If "Yes," give details, including description of duties and hours worked per week.)

- f) If this application is for Individual Disability Income Insurance, will your employer pay the premium for this coverage? Yes No
- g) If yes, what 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.)

Disability Income

Occupation and Financial Details

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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:

Application for Insurance

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. In the past three years, ever made any flights as: a pilot, student pilot, or crew member of any aircraft, or intend to do so? *(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

<input type="checkbox"/> Motorized Racing	<input type="checkbox"/> Scuba diving
<input type="checkbox"/> Parachuting/Skydiving	<input type="checkbox"/> Hang-gliding
<input type="checkbox"/> Ballooning	<input type="checkbox"/> Mountain climbing
<input type="checkbox"/> Rodeo	<input type="checkbox"/> Competitive skiing
<input type="checkbox"/> Snowmobiling	<input type="checkbox"/> Gliding
<input type="checkbox"/> Boat racing	<input type="checkbox"/> 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.)*

Application for Insurance

Health Questionnaire

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Name of Proposed Insured: _____

Health Questions. Please provide 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. To the best of your knowledge and belief, 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, excluding AIDS, or HIV? 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, other than an HIV test? Yes No
 - b) Been advised by a licensed medical professional to have any diagnostic test, other than an HIV 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 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 AIDS Related Complex (ARC)? 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 Questionnaire page, UN 2550 HQ NY, or additional sheet of paper, 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, (except for substance abuse treatment program records for which special authorization is required) or tobacco, HIV, AIDS and sexually transmitted diseases, prescription drug records, financial status, education records, employment status or other relevant data or facts about the proposed insured or claimant; including wage and earnings, or data or facts with respect to other insurance coverage; to give all data or facts to the companies listed above ("the Companies"), their reinsurers, or any other agent or agency acting on the Companies' behalf.

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

The above data and facts will be used to: (1) underwrite an application for coverage; (2) obtain reinsurance; (3) resolve or contest any issues of incomplete, incorrect, or misrepresented information on the application identified above which may arise during the processing or review of the application, or any other application for insurance; (4) administer coverage and claims; and (5) complete a consumer report, investigative consumer report or telephone interview about the proposed insured or claimant.

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

I acknowledge receipt of Notice of Insurance Information Practices.

Dated at: _____
City State Month Day Year

Print or Type Name of Proposed Insured

X _____
Signature of Proposed Insured

Print or Type Name of Other Proposed Insured

X _____
Signature of Other Proposed Insured

Print or Type Name of Personal Representative of Proposed Insured

X _____
Signature of Personal Representative of Proposed Insured

Description of Authority of Personal Representative
(Parent, Legal Guardian, Attorney-in-Fact)
(Attach documentation in support of your authority.)

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Application for Insurance Agreement

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Agreement

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

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

If applying for an indeterminate premium plan:

- (a) the premium for such plan is guaranteed for the initial guarantee period, and after such period, the current annual premium is not guaranteed and may change; and
- (b) the premium will never exceed the specified maximum.

Fraud Notice

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

Dated at: _____
City State Month Day Year

Print or Type Proposed Insured Name.

X

Signature of Proposed Insured.

Print or Type Name of Other Proposed Insured.

X

Signature of Other Proposed Insured.

Print or Type Owner if not Proposed Insured.

X

Signature of Owner if not Proposed Insured.

Print or Type Insurance Producer Name.

Producer No./Sit. Code.

X

Signature of Licensed Soliciting Producer.

Producer State Lic. No.

Print or Type Insurance Producer Name.

Producer No./Sit. Code.

X

Signature of Licensed Soliciting Producer.

Producer State Lic. No.

Agency Name.

Agency No.

Taxpayer Identification Number (TIN)

Social Security Number

Employer Identification Number

Under penalties of perjury, I certify that:

- 1) The number shown on this form is my correct TIN (or I am waiting for a number to be issued to me); and
- 2) I am not subject to backup withholding either because: (a) I am exempt from backup withholding; (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends; or (c) the IRS has notified me that I am no longer subject to backup withholding.

- 3) I am a U.S. Citizen or other U.S. Person (including a U.S. resident alien).

Cross out item (2) if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return.

X

Signature of Owner, Trustee/Employer

Date

Application for Insurance

Producer's Statement

First Ameritas Life Insurance Corp. of New York
P.O. Box 40888, Cincinnati, OH 45240
800-319-6901, Fax 513-595-2352
(Client Service Office)

The Union Central Life Insurance Company
P.O. Box 40888, Cincinnati, OH 45240
800-319-6901, Fax 513-595-2532
(Client 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: _____

Application for Insurance

Conditional Receipt

First Ameritas Life Insurance Corp. of New York
P.O. Box 40888, Cincinnati, OH 45240
800-319-6901, Fax 513-595-2352
(Client Service Department)

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. 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 until delivery of the policy. The "coverage date" is the date of this application or Part II or medical examination or other test initially required by published rules of the companies listed above ("the Companies") used when considering the benefits applied for, whichever date is latest. If a policy is issued under this receipt and application as of the "coverage date," the maximum amount limitation of this receipt will apply until the policy/policies is/are delivered. If the application is declined, the premium paid will be returned.

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. 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)



First Ameritas Life Insurance Company of New York
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)

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: _____

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 Account Holder: _____
(Print Name as shown on Bank Records) (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) (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)



First Ameritas Life Insurance Corp.
 P.O. Box 40888, Cincinnati, OH 45240
 800-319-6901, Fax 513-595-2352
 (Client Service Department)

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

HIV ANTIBODY TEST

Information Form For insurance Applicant

AIDS

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

The HIV Antibody Test

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

1. **Purpose.** This test is being run to determine whether you may have been infected with HIV. If you are infected, you are probably not insurable. This test is not a test for AIDS; AIDS can only be diagnosed by medical evaluation.
2. **Positive Test Results.** If you test positive, you should seek medical follow-up with your personal physician. If your test is positive, you may be infected with HIV, may develop AIDS, and may wish to consider further independent testing.
3. **Accuracy.** An HIV test will be considered positive only after confirmation by a laboratory procedure that the state health officer has determined to be highly accurate. Nonetheless, the HIV antibody test is not 100% accurate. Possible errors include:
 - a. **False positives:** The test gives a positive result, even though you are not infected. This happens only rarely and is more common in persons who have not engaged in high risk behavior. Retesting should be done to help confirm the validity of a positive test.
 - b. **False negatives:** The test gives a negative result, even though you are infected with HIV. This happens most commonly in recently infected persons; it takes at least 4-12 weeks for a positive test result to develop after a person is infected.
4. **Side Effects.** A positive test result may cause you significant anxiety. A positive test may result in uninsurability for life, health, or disability insurance policies you may apply for in the future. Although prohibited by law, discrimination in housing, employment, or public accommodations may result if your test results were to become known to others. A negative result may create a false sense of security.
5. **Disclosure of Results.** A positive test result will be disclosed to you. You may choose to have information about your HIV test results communicated to you through your physician or through the alternative testing site.
6. **Confidentiality.** Like all medical information, HIV test results are confidential. An insurer, insurance agent, or insurance-support organization is required to maintain the confidentiality of HIV test results. However, certain disclosures of your test results may occur, including those authorized by consent forms that you may have signed as part of your overall application. Your test results may be provided to the Medical Information Bureau, a national insurance data bank. Your insurance agent will provide you with additional written information about this subject at your request.
7. **Prevention.** Persons who have a history of high risk behavior should change these behaviors to prevent getting or giving AIDS, regardless of whether they are tested. Specific important changes in behavior include safe sex practices (including condom use for sexual contact with someone other than a long-term monogamous partner) and not sharing needles.
8. **Information.** For additional information about HIV and AIDS, the meaning of HIV test results, and the availability and location of HIV counseling services, you may call the New York AIDS Hotline at 1-800-541-AIDS.
 Name of Physician or other person/entity

Informed Consent

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

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

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

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

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

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

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

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

(Name and address of attending physician)

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

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

Dated at _____ Day _____ Month _____, year _____.

Witness _____
Agent (Signature)

Proposed Insured/
Parent or Guardian _____
(Signature)

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

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

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

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

What can I do to help?

Know the facts about HIV and AIDS.

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

Set an example for others.

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

Become a volunteer.

Sponsor an AIDS fund-raising event or donate money.

Become a Red Cross HIV/AIDS instructor.

For more information, contact—

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

American Red Cross HIV/AIDS Programs

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

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



American Red Cross

Together, we can save a life

This publication was supported by Cooperative Agreement No. U62/CCU 303031 from the Centers for Disease Control and Prevention (CDC) of the U.S. Public Health Service. Its contents are solely the responsibility of the American Red Cross and do not necessarily represent the official views of the CDC.



Together, we can save a life

HIV AND AIDS



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

FACT: AIDS is caused by a virus called HIV.

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

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

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

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

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

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

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

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

You cannot get HIV from—

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

You cannot get HIV from using—

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

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

People become infected with HIV by:

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

FACT: You can protect yourself and others from HIV.

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

- Have sex only with one partner who is not infected, who has sex only with you and who does not share needles or syringes. (Keep in mind that it is difficult to know these things about another person.)
- Avoid contact with your partner's blood, semen or vaginal fluid.
- Use latex (or polyurethane) condoms consistently and correctly during sex.

- Use a water-based lubricant with a latex (or polyurethane) condom for vaginal or anal sex to reduce the risk of breakage.
- Use a dental dam during oral sex to help reduce the risk of transmitting HIV or other sexually transmitted diseases.

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

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

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

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

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

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

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

FACT: There are tests for HIV.

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

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

Application for Insurance Authorization

First Ameritas Life Insurance Corp. of New York

P.O. Box 40888, Cincinnati, OH 45240
800-319-6901, Fax 513-595-2218
(Client Service Department)

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

I acknowledge receipt of Notice of Insurance Information Practices.

Dated at: _____
City State Month Day Year

Print or Type Name of Proposed Insured

X _____
Signature of Proposed Insured

Print or Type Name of Other Proposed Insured

X _____
Signature of Other Proposed Insured

Print or Type Name of Personal Representative of Proposed Insured

X _____
Signature of Personal Representative of Proposed Insured

Description of Authority of Personal Representative
(Parent, Legal Guardian, Attorney-in-Fact)
(Attach documentation in support of your authority.)



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Electronic Fund Transfer Form

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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: _____

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 Account Holder: _____
(Print Name as shown on Bank Records) (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

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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) (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)