



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?

<b>Application Kit</b>	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.

**CHECK THE COMPANIES THAT APPLY:**

**First Ameritas Life Insurance Corp. of New York**  
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**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: \_\_\_\_\_

### The Union Central Life Insurance Company

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#### 1. Individual Disability Income Insurance:

- a) Contract Form to include: (*Definition Of Disability*)
- UC 4401(65): An "own occ" definition for the entire benefit period.
  - UC 4401(65NW): An "own occ and not engaged in any" definition for the entire benefit period.
  - UC 4401(60): An "own occ" definition for 60 months and then "any reasonable occ" thereafter.
  - UC 4401(60NW): An "own occ and not engaged in any" definition for 60 months and then "any reasonable occ" thereafter.
  - UC 4401(24): An "own occ" definition for 24 months then "any reasonable occ" thereafter. The definition of disability cannot exceed the benefit period.
  - UC 4401(24HP): An "own occ and not engaged in any" definition for 24 months and then an "ADL" definition thereafter.
  - UC 4402: Guaranteed Renewable Series.
- b) Base Monthly Benefit: \$ \_\_\_\_\_
- c) Waiting Period (Days):
- 30     60     90
  - 180     365     730
- d) Benefit Period ("BP"):
- 1 Year     2 Years     5 Years
  - To Age 65     To Age 67
- e) Optional Riders:
- Residual Disability Rider
  - Residual Disability Rider (24 Months) For Age 65 or 67 BP only
  - Partial Disability Rider
  - Cost of Living Adjustment Rider
  - Social Insurance Substitute Rider:  
Amount: \$ \_\_\_\_\_ Waiting Period (Days): \_\_\_\_\_
  - Catastrophic Disability Rider:  
Amount: \$ \_\_\_\_\_ Waiting Period (Days): \_\_\_\_\_  
Benefit Period (Years): \_\_\_\_\_
  - Future Increase Option Rider: Amount: \$ \_\_\_\_\_
  - Automatic Increase Rider
  - Other: \_\_\_\_\_
- f) Do you understand and agree that under the terms of the Individual Disability Income policy applied for, no monthly benefit is payable during the waiting period of any disability?
- Yes     No

#### 2. Disability Overhead Expense:

- a) Base Monthly Benefit: \$ \_\_\_\_\_
- b) Waiting Period (Days):
- 30     60     90
- c) Benefit Period (Months):
- 12     18     24
- d) Optional Riders:
- Future Increase Rider: Amount: \$ \_\_\_\_\_
  - Substitute Salary Expense Rider: Amount: \$ \_\_\_\_\_
- e) Do you understand and agree that under the terms of the Disability Overhead Expense policy applied for, no monthly benefit is payable during the waiting period of any disability?
- Yes     No

#### 3. Premium:

- a) Premium Payor:
- Insured     Employer
  - Other \_\_\_\_\_
- b) Send Premium Notices to:
- Residence     Other (*Specify relationship and address.*) \_\_\_\_\_
  - Business \_\_\_\_\_
- 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: \$ \_\_\_\_\_
- Disability Overhead Expense: \$ \_\_\_\_\_
- Total: \$ \_\_\_\_\_

#### 4. Occupation / Employment:

- 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? \_\_\_\_\_
- d) How many total employees are there in the business where you work? \_\_\_\_\_
- e) How long have you been employed at the business where you work? \_\_\_\_\_
- f) How many hours per week do you work in your primary occupation? \_\_\_\_\_
- g) How long have you worked in your primary occupation? \_\_\_\_\_
- h) 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.*) \_\_\_\_\_
- i) If this application is for Individual Disability Income Insurance, will your employer pay the premium for this coverage?  Yes     No
- j) If yes, what percent will be paid by the employer? \_\_\_\_\_ %
- k) If yes, will the premium paid by the employer be included in your taxable income?  Yes     No
- l) 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

### 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:  
\_\_\_\_\_  
\_\_\_\_\_

# Application for Insurance

## Lifestyle Questionnaire

### First Ameritas Life Insurance Corp. of New York

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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

### First Ameritas Life Insurance Corp. of New York

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### The Union Central Life Insurance Company

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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.*)



# Application for Insurance

## 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.)

# Application for Insurance

## Agreement

### First Ameritas Life Insurance Corp. of New York

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### The Union Central Life Insurance Company

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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

## 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 Department)

### The Union Central Life Insurance Company

P.O. Box 40888, Cincinnati, OH 45240  
800-319-6901, Fax 513-595-2352

#### 1. Background Information

- a) How well acquainted are you with the purchaser?
- |  |                                     |
|--|-------------------------------------|
| <input type="checkbox"/> First Contact                           | <input type="checkbox"/> Well Known |
| <input type="checkbox"/> Casually                                | <input type="checkbox"/> Self       |
| <input type="checkbox"/> Relative ( <i>relationship</i> ): _____ |                                     |
- b) Initial contact with purchaser?
- |  |   |
|--|---|
| <input type="checkbox"/> Friend/Relative | <input type="checkbox"/> Direct-Mail Lead |
| <input type="checkbox"/> Referred Lead   | <input type="checkbox"/> Home-Office Lead |
| <input type="checkbox"/> Cold Call       |   |
| <input type="checkbox"/> Other: _____    |   |
- c) Marital Status:
- |                                   |                                  |
|-----------------------------------|----------------------------------|
| <input type="checkbox"/> Single   | <input type="checkbox"/> Married |
| <input type="checkbox"/> Divorced | <input type="checkbox"/> 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
- |  |  |
|--|--|
| <input type="checkbox"/> Survivor Needs                  | <input type="checkbox"/> Mortgage Acceleration |
| <input type="checkbox"/> Spouse Insurance                | <input type="checkbox"/> Income Replacement    |
| <input type="checkbox"/> Education Funding               | <input type="checkbox"/> Retirement Funding    |
| <input type="checkbox"/> Other ( <i>specify</i> ): _____ |  |
- e) Business
- |  |   |
|--|---|
| <input type="checkbox"/> Key Person                      | <input type="checkbox"/> Deferred Compensation      |
| <input type="checkbox"/> Business Purchase               | <input type="checkbox"/> Executive Bonus (Sec. 162) |
| <input type="checkbox"/> Cover Debt                      | <input type="checkbox"/> Split Dollar               |
| <input type="checkbox"/> Other ( <i>specify</i> ): _____ |   |
- f) Estate
- |  |   |
|--|---|
| <input type="checkbox"/> Charitable Gifts                | <input type="checkbox"/> Fund Trusts for Heirs      |
| <input type="checkbox"/> Estate Tax                      | <input type="checkbox"/> Equalization between Heirs |
| <input type="checkbox"/> Other ( <i>specify</i> ): _____ |   |

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

- Alternate Policy  
 Additional Policy  
(If requested, provide details): \_\_\_\_\_

#### 6. Disability Income Insurance Information

- Occupational Class Quoted:
- |                                       |                             |                             |                              |
|---------------------------------------|-----------------------------|-----------------------------|------------------------------|
| <input type="checkbox"/> 5AP          | <input type="checkbox"/> 5A | <input type="checkbox"/> 4A | <input type="checkbox"/> 3AP |
| <input type="checkbox"/> 3A           | <input type="checkbox"/> 2A | <input type="checkbox"/> A  | <input type="checkbox"/> B   |
| <input type="checkbox"/> Other: _____ |                             |                             |                              |

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: \_\_\_\_\_

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 its 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)



**First Ameritas Life Insurance Corp.**  
 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

## 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)