

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 Personal Information

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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: _____



Application for Insurance Personal Information (continued)

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1. Proposed Insured (Two):

- a) Name: _____
- b) Date of Birth: _____ c) Sex: Male Female
- d) Place of Birth: _____
- e) Social Security/Tax ID No.: _____
- f) Driver's License or other Government issued 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: _____

3. Proposed Insured: (Child One or Other.)

- a) Name: _____
- b) Relationship: _____
- c) Date of Birth: _____ d) Sex: Male Female
- e) Place of Birth: _____
- f) Social Security No: _____
- g) Ins. in Force/Company: _____
- h) Driver's License No: _____

2. Owner Information (Two):

(Complete only if Owner is other than Proposed Insured.)

- a) Individual b) Trust (provide copy) c) Partnership
- d) Corporation: County of Incorporation: _____
- e) Full Name: _____
- f) Relationship to Proposed Insured(s): _____
- g) Trustee(s) Name: _____
- h) Date of Birth or Date of Trust: _____
- i) Social Security/Tax ID No.: _____
- j) Driver's License or other Government issued 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.: _____

4. Proposed Insured: (Child Two or Other.)

- a) Name: _____
- b) Relationship: _____
- c) Date of Birth: _____ d) Sex: Male Female
- e) Place of Birth: _____
- f) Social Security No: _____
- g) Ins. in Force/Company: _____
- h) Driver's License No: _____



Universal Life/Traditional Life Policy Details

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1. Universal Life:

- a) Specified Amount (*base only*): \$ _____
Plan of Insurance: _____
- b) Death Benefit Option:
 - Option A (*Specified Amount*)
 - Option B (*Specified Amount plus Account Value*)
 - Option C (*Return of Premium*)
- c) Life Insurance Qualification Test:
 - GPT (*Guideline Premium Test*)
 - CVAT (*Cash Value Accumulation Test*)
- d) Planned Periodic Premium (*modal*): \$ _____
Additional First-Year Premium (*lump-sum deposits*): \$ _____
- e) Single Life Supplementary Benefits:
 - Accelerated Benefit Rider (*include Disclosure Statement*)*
 - Accidental Death Benefit Rider: \$ _____
 - Children's Insurance Rider: \$ _____
 - Guaranteed Insurability Rider: \$ _____
 - Scheduled Increase Rider: _____ %
 - Supplemental Coverage Rider: \$ _____
 - Term Insurance Rider: \$ _____
 - Term Insurance Rider for Other Insured: \$ _____
 - Total Disability Benefits Rider: \$ _____
 - Waiver of Monthly Deduction Rider
 - Other: _____
- f) Survivorship Supplementary Benefits:
 - Estate Protection Rider
 - Policy Split Rider
 - Term Insurance Rider for Other Insured (Insured One)
 - To Age: _____ Amount: \$ _____
 - Term Insurance Rider for Other Insured (Insured Two)
 - To Age: _____ Amount: \$ _____
 - Total Disability Benefit Rider (Insured One)
 - Amount: \$ _____
 - Total Disability Benefit Rider (Insured Two)
 - Amount: \$ _____
 - Waiver of Monthly Deductions Rider (Insured One)
 - Waiver of Monthly Deductions Rider (Insured Two)
 - Other: _____
- g) Indexed UL Account Allocations:
 - _____ % Fixed Account: a current interest rate.
 - _____ % Capped Participation Account: a 100% participation rate on a limited percentage increase in the S & P Index.
 - _____ % Uncapped Participation Account: a lower participation rate on unlimited percentage increases in the S & P Index.

100 % Total

2. Whole Life:

- a) Specified Amount: \$ _____
Plan of Insurance: _____
- b) Dividend Option:
 - Paid-Up additions
 - Cash
 - Accumulate at Interest
 - Reduce premium (*not on monthly modes*)
 - One-year term
 - One-year term equal to cash value
 - Other: _____
- c) Nonforfeiture Option:
 - Extended Term Insurance
 - Reduce Paid Up
 - Automatic Premium Loan Yes No
- d) Supplementary Benefits:
 - Accelerated Benefits Rider (*include Disclosure Statement*)*
 - Accidental Death Benefit Rider: \$ _____
 - Guaranteed Insurability Rider: \$ _____
 - One Year Term Rider: \$ _____
 - Paid-Up Rider:
 - Annual Premium: \$ _____
 - Single Premium: \$ _____
 - Term Paid-Up Rider (*TPL*): \$ _____
 - Total Disability Benefit Rider
 - Waiver of Premium Rider
 - Other: _____

3. Premium:

- a) Send Premium Notices to: Residence Business
 - Owner Other: (*Specify relationship and address*)
 - Insured _____
- b) Premium Frequency:
 - Annual Electronic Fund Transfer (*complete EFT form*)
 - Semi-Annual Salary Allotment
 - Quarterly Other: _____
- c) Has any premium been given in connection with this application? Yes No (*If "Yes," state amount paid for which conditional receipt has been given; the terms of which are hereby agreed to.*)
Amount: \$ _____

*Receipt of accelerated death benefits may affect eligibility for public assistance programs and may be taxable. We will treat the accelerated benefit plus accrued interest as a lien against the death benefit proceeds.

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1. Existing and Pending Insurance - Proposed Insured(s):

	Proposed Insured One	Proposed Insured Two
a) Total insurance in force on the Proposed Insured(s).	\$ _____	\$ _____
b) Total insurance currently pending with all companies, including this application.	\$ _____	\$ _____
c) Of the above pending amount, how much do you intend to accept? \$ _____	\$ _____	\$ _____
d) Provide information for each policy in force on the Proposed Insured(s). <i>(Attach additional page if necessary.)</i>		
Proposed Insured: <input type="checkbox"/> One <input type="checkbox"/> Two		
Company: _____		
Group, Personal or Business: _____		
Issue Date: _____		
To Remain in Force? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Face Amount: _____		
Proposed Insured: <input type="checkbox"/> One <input type="checkbox"/> Two		
Company: _____		
Group, Personal or Business: _____		
Issue Date: _____		
To Remain in Force? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Face Amount: _____		
e) Have you ever sold, assigned, or pledged as collateral a life insurance policy, or an interest in a life insurance policy? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If "Yes," give details.)</i>		

2. Existing Insurance (Replacement):

a) Do you have any existing life insurance policies or annuity contracts? Yes No *(If "Yes," complete a Replacement Notice if required by State Law.)*

b) Will any life insurance policy or annuity contract presently in force with this or any other company be discontinued, reduced, changed, or replaced if insurance now applied for is issued?
 Yes No *(If "Yes," give details.)*

Company: _____ Policy No.: _____

Amount: \$ _____ Date: _____

Type of Policy: _____

3. Insurance Producer's Replacement Statement:

a) To the best of your knowledge, does the applicant have any existing insurance policies or annuity contracts? Yes No

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

Company: _____ Policy No.: _____

c) Will a policy loan on one or more policies be utilized to pay any portion of the initial premium or deposit on the policy applied for?
 Yes No *(If "Yes," give policy number(s) involved.)*

4. Statement of Intent:

a) Is there, or will there be, any agreement or understanding that provides for a party, other than the Owner, to obtain any interest in any policy issued on the life of the proposed insured as a result of this application? Yes No

b) Will the premiums be financed through a loan? Yes No
(If "Yes," list: lender, duration of loan, and collateral required.)

c) Will any entity other than a life insurance company be medically evaluating the proposed insured either to obtain financing or to determine life expectancy? Yes No *(If "Yes," give details.)*

d) Will the policy, if issued, be placed in a trust? Yes No
(If "Yes," give details and provide copy of trust.)

5. Financial Questions:

	Proposed Insured One	Proposed Insured Two
a) Gross annual earned income: <i>(salary, commissions, bonuses, etc.)</i>	\$ _____	\$ _____
b) Gross annual unearned income: <i>(dividend, interest, net real estate income, etc.)</i>	\$ _____	\$ _____
c) Household net worth: \$ _____		
d) In the last 5 years, has either of the Proposed Insured(s) or the business had any major financial problems <i>(bankruptcy, etc.)</i> ? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If "Yes," give details.)</i>		
e) If Owner, other than the proposed insured, is an individual:		
Net Worth: \$ _____		
Net Annual Income: \$ _____		
Total Family Income: \$ _____		

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

Current Income Cash Savings Employer

Securities Relative Premium Finance

Sale of personal property or real estate.

Insurance/Annuities (Loans/Withdrawals).

1035 Exchange

Insurance or annuity maturity value or death benefit.

Rollover/Transfer of 401(k) or Pension Funds.

Other: _____

7. Business Insurance: *(Complete for ALL Business Owned Insurance.)*

	Current Year	Previous Year
a) Assets:	\$ _____	\$ _____
b) Liabilities:	\$ _____	\$ _____
c) Gross Sales:	\$ _____	\$ _____
d) Net Income after taxes:	\$ _____	\$ _____
e) Fair Market Value of the business:	\$ _____	\$ _____
f) What percentage of the business is owned by Proposed Insured(s)? _____ %		
g) Are other partners / owners / executives being insured? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If "Yes," give details.)</i>		

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.*)



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

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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: _____

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. of New York

ACCELERATED BENEFIT RIDER FOR TERMINAL ILLNESS DISCLOSURE STATEMENT

We will pay an accelerated benefit if the *insured* has a terminal illness that was first diagnosed while the policy was in force. *You* must provide satisfactory proof that the *insured* has less than 12 months to live in accordance with the terms of the rider. The accelerated benefit that *you* may receive will be no less than the lower of 25% of the eligible amount and \$50,000, and no greater than 50% of the eligible amount. The eligible amount includes the current *specified amount* or face amount of the policy, any paid-up additions, and any term insurance rider on the same *insured* as the policy. The eligible amount does not include accidental death benefit riders or any coverage within one year of its maturity or expiration date.

This Accelerated Benefit Rider is NOT a long-term care policy. The amount this rider pays may not be enough to cover nursing home or other bills. Other means may be available to achieve your intended goal, including a policy loan.* *You* may use the money received from this rider for any purpose.

Benefits payable under this rider may be taxable. *You* should consult *your* personal tax advisor before applying for such benefits. We will treat the accelerated benefit plus accrued interest as a lien against the death benefit proceeds.

Receipt of accelerated death benefits MAY affect eligibility for public assistance programs, such as medical assistance (Medicaid), aid to families with dependent children, and supplemental security income. Before applying for accelerated death benefits, *you* should consult with the appropriate social service agency concerning how receipt will affect the eligibility of *you* and/or *your* spouse or dependents.

We may charge a one-time administrative fee not to exceed .5% of the accelerated benefit amount for processing a benefit under this rider. This fee will be applied to the lien and deducted from the death benefit at the time of death.

We are prohibited from paying the benefits for a period of 14 days from the date on which *you* were furnished a numerical computation of the amount of the death benefit. This computation will be provided not later than five days after *your* application is received.

No health care facility, as defined in Section 20 of the New York Public Health Law, can require any person to accelerate payment of a death benefit as a condition of admission to such health care facility or for providing any care in such facility.

Following is an example of the effect of this benefit on the policy's death benefit. The values shown are hypothetical and do not reflect *your* policy's actual values:

Issue Age	45
Age at acceleration	55
Face Amount	\$250,000.00
Accelerated Death Benefit (Lien Amount)	\$ 125,000.00
50% of Maximum Accelerated Death Benefit	\$62,500
Lien Interest Rate Maximum	8.00%
Maximum Fee (0.5% of Accelerated Benefit)	\$312.50
Cash Value (Not affected by ABR)*	\$50,000.00
Cash Surrender Value (Cash Surrender Value - Lien Amount)*	\$ -
Cash Value Available for Loan (Cash Surrender Value - Lien Amount)*	\$ -
Pre-existing policy loan (paid off with Accelerated Benefit proceeds)*	\$10,000.00
Monthly Premium Assumed	\$400.00
Policy Loan Interest Rate*	5.00%
Amount Paid to Policyholder (Accelerated Amount minus loan*)	\$52,500

Hypothetical Values

Beginning of Month	Premium Added to Lien	(Lien Amount) Accelerated Amount +Premium+ Interest+Fee	NonAccelerated Death Benefit Remaining	Total Death Benefit (Sum of Lien & Non Accelerated DB)	Cash Value Available for Surrender or Loan*	Policy Loan*
1	\$400.00	\$63,212.50	\$186,787.50	\$250,000.00	\$-	\$-
2	\$400.00	\$64,019.21	\$185,980.79	\$250,000.00	\$-	\$-
3	\$400.00	\$64,831.11	\$185,168.89	\$250,000.00	\$-	\$-
4	\$400.00	\$65,648.24	\$184,351.76	\$250,000.00	\$-	\$-
5	\$400.00	\$66,470.62	\$183,529.38	\$250,000.00	\$-	\$-
6	\$400.00	\$67,298.29	\$182,701.71	\$250,000.00	\$-	\$-
7	\$400.00	\$68,131.29	\$181,868.71	\$250,000.00	\$-	\$-
8	\$400.00	\$68,969.65	\$181,030.35	\$250,000.00	\$-	\$-
9	\$400.00	\$69,813.41	\$180,186.59	\$250,000.00	\$-	\$-
10	\$400.00	\$70,662.59	\$179,337.41	\$250,000.00	\$-	\$-
11	\$400.00	\$71,517.23	\$178,482.77	\$250,000.00	\$-	\$-
12	\$400.00	\$72,377.38	\$177,622.62	\$250,000.00	\$-	\$-
13	\$400.00	\$73,243.05	\$176,756.95	\$250,000.00	\$-	\$-

*If applicable (Term life insurance will not have cash values, surrender values or loans)

Owner's Signature

Agent

Date

Date



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)

CHECK ALL COMPANIES THAT APPLY:

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

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

INSURANCE DEPARTMENT OF THE STATE OF NEW YORK

DEFINITION OF REPLACEMENT

In order to determine whether you are replacing or otherwise changing the status of existing life insurance policies or annuity contracts, and in order to receive the valuable information necessary to make a careful comparison if you are contemplating replacement, the agent/broker is required to ask you the following questions and explain any items that you do not understand.

As part of your purchase of a new life insurance policy or a new annuity contract, has existing coverage been, or is it likely to be:

1. Lapsed, surrendered, partially surrendered, forfeited, assigned to the insurer replacing the life insurance policy or annuity contract, or otherwise terminated? Yes No
2. Changed or modified into paid-up insurance; continued as extended term insurance or under another form of nonforfeiture benefit; or otherwise reduced in value by the use of nonforfeiture benefits, dividend accumulations, dividend cash values or other cash values? Yes No
3. Changed or modified so as to effect a reduction either in the amount of the existing life insurance or annuity benefit or in the period of time the existing life insurance or annuity benefit will continue in force? Yes No
4. Reissued with a reduction in amount such that any cash values are released, including all transactions wherein an amount of dividend accumulations or paid-up additions is to be released on one or more of the existing policies? Yes No
5. Assigned as collateral for a loan or made subject to borrowing or withdrawal of any portion of the loan value, including all transactions wherein any amount of dividend accumulations or paid-up additions is to be borrowed or withdrawn on one or more existing policies? Yes No
6. Continued with a stoppage of premium payments or reduction in the amount of premium paid? Yes No

If you have answered yes to any of the above questions, a replacement as defined by New York Insurance Department Regulation No. 60 has occurred or is likely to occur and your agent is required to provide you with a completed Disclosure Statement and the **IMPORTANT** Notice Regarding Replacement or Change of Life Insurance Policies or Annuity Contracts.

Date _____ Signature of Applicant _____

Date _____ Signature of Applicant _____

To the best of my knowledge, a replacement is involved in this transaction: Yes No

Date _____ Signature of Agent/Broker _____

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

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

Policy Illustration Certification

Typically a "policy illustration" is provided to help you understand, in general terms, how a policy will work. A policy illustration shows policy premiums, death benefits, cash values and information about other items that can affect the performance of your policy. Because a hard copy of the policy illustration for the specific policy you are applying for was not provided, we ask that both you and your agent acknowledge statements 1 and 2:

1. That an illustration reflecting the policy applied for was delivered at the time of application by electronic media in either one of two forms; and

Electronic Mail (e-mail)

• E-mail address: _____

Compact disc (CD).

2. That a hard copy illustration reflecting the actual policy issued as a result of this application will be provided at the time of policy delivery.

Applicant (print name) _____

Applicant's Signature _____ Date _____

Agent (print name) _____ Agency No. _____

Agent's Signature _____

Proposed Insured (if different than applicant) _____

Instructions to Agent

Submit signed and dated form with the application to Individual Life Client Services in the Home Office.