Application for Insurance

Notice of Insurance Information Practices

Acacia Life Insurance Company
P.O. Box 81889, Lincoln, NE 68501
800-745-1112, Fax 402-467-7335
(Client Service Department)

Ameritas Life Insurance Corp.
P.O. Box 81889, Lincoln, NE 68501
800-745-1112, Fax 402-467-7335

The Union Central Life Insurance Company
P.O. Box 40888, Cincinnati, OH 45240
800-319-6901, Fax 513-595-2218

To issue an insurance policy we need to obtain information about you and any other persons proposed for insurance. Some of that information will come from you and some will come from other sources. We may obtain information relating to any proposed insured's mental and physical health, general character and reputation, habits, finances, occupation, other insurance coverage, or participation in hazardous activities.

This information may be obtained from physicians, medical professionals, hospitals, clinics or other medical care institutions, or from the Medical Information Bureau, Inc. (MIB), public records, consumer reporting agencies, financial sources, other insurance companies, agents, friends, neighbors and associates. We may obtain information through exchanges or correspondence, by telephone or by personal contact.

Information regarding your insurability or claims will be treated as confidential. The companies listed above ("the Companies") or their reinsurers may, however, make a brief report thereon to the Medical Information Bureau, Inc. (MIB), a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file. Upon receipt of a request from you, the MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill, Suite 400, Braintree, Massachusetts 02184-8734; telephone number (866) 692-6901 (TTY 866-346-3642). The Companies or their reinsurers may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

Furthermore, as part of our procedure for processing your insurance application, an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends, associates, or others with whom you are acquainted. This inquiry and any subsequent investigative consumer report update which may also be requested includes information as to your character, general reputation, personal characteristics, and mode of living.

You have the right to be personally interviewed if we order an investigative consumer report. Please notify our agent if this is your wish. You are also entitled to receive a copy of the investigative consumer report whether or not an interview is conducted. You also have the right to make a written request within a reasonable period of time to receive additional, detailed information about the nature and scope of this investigation.

To reduce costs and offer insurance coverage at the lowest possible premium, the Companies may also use a Personal History Interview. A specially trained interviewer may call to discuss information contained in your application or to ask questions related to the underwriting of your insurance. We will attempt to conduct this telephone interview at your convenience and at a number you designate.

In the event of an adverse underwriting decision, upon written request, we will provide you with the specific reason in writing for that adverse underwriting decision.

As a general practice, we will not disclose personal information about you to anyone else without your consent, unless a legitimate business need exists or disclosure is required or permitted by law. A description of the circumstances under which information about you might be disclosed without your authorization will be sent to you upon request.

You have a right of access to personal information we maintain in our files and to request correction, amendment, or deletion of any information you believe to be incorrect. You may request a description of established procedures which will allow access to and correction of such personal information.

If you wish to have a more detailed explanation of our information practices, including your rights of access to and correction of personal information, please contact the Underwriting Department at the above address.

DETACH AND DELIVER TO PROPOSED INSURED BEFORE COMPLETION OF THE APPLICATION.

UNIFI®
Companies

Part II – Medical

CHECK ALL COMPANIES THAT APPLY:

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

Health Questions. Please complete Details for "Yes" answers.

1. a. Height: ____________ b. Weight: ____________
   c. Have you lost 10 lbs. or more in the past 12 months? ☐ Yes ☐ No
   d. Have you gained 10 lbs. or more in the past 12 months? ☐ Yes ☐ No
2. Have you ever been medically treated for or had any known indication of:
   a. Disorder of eyes, ears, nose, or throat? . . . . ☐ Yes ☐ No
   b. Dizziness, vertigo, fainting, seizures, recurrent headache; speech defect, paralysis, or stroke? . . . ☐ Yes ☐ No
   c. Shortness of breath, bronchitis, pleurisy, asthma, emphysema, tuberculosis or chronic respiratory disorder? ☐ Yes ☐ No
   d. Chest pain, palpitation, high blood pressure, heart murmur, heart attack or other disorder of the heart or blood vessels? ☐ Yes ☐ No
   e. Jaundice, intestinal bleeding; ulcer, hernia, colitis, hepatitis, diverticulitis, recurrent indigestion or other disorder of the stomach, intestines, liver or gallbladder? ☐ Yes ☐ No
   f. Sugar, albumin, blood or pus in urine; sexually transmitted disease; stone or other disorder of kidney or bladder?. . ☐ Yes ☐ No
   g. Diabetes, thyroid, or other endocrine disorders? . . ☐ Yes ☐ No
   h. Disorder of breasts, reproductive organs, or prostate? . ☐ Yes ☐ No
   i. Neuritis, arthritis, rheumatism, gout, or disorder of or injury to the bones, muscles, nerves, knees, wrists or other joints? ☐ Yes ☐ No
   j. Disorder of skin, lymph glands, cyst, tumor or cancer? ☐ Yes ☐ No
   k. Allergies, anemia or other disorder of the blood? . . ☐ Yes ☐ No
   l. Spinal, neck or back disorder or injury, including sprains, strains, or disc disorder?. . . . . ☐ Yes ☐ No
   m. Anxiety, depression, stress or other mental, nervous, psychiatric or emotional disorder? . . . . ☐ Yes ☐ No
   n. Chronic fatigue, fibromyalgia, or Epstein-Barr virus? ☐ Yes ☐ No
   o. C-section, miscarriage, or complication of pregnancy? ☐ Yes ☐ No
   p. Any mental or physical disorder not listed above? . ☐ Yes ☐ No
3. Have you ever consulted a chiropractor?. . . . . ☐ Yes ☐ No
4. Are you currently pregnant? . . . . ☐ Yes ☐ No
5. Other than noted above, have you within the past five years:
   a. Had a checkup, consultation, illness, injury, or surgery; been a patient in a hospital, clinic, sanatorium, or other medical facility; had an electrocardiogram, X-ray, or other diagnostic test? . . . . ☐ Yes ☐ No
   b. Been advised by a licensed medical professional to have any diagnostic test, hospitalization, or surgery which was not completed?. . . . . ☐ Yes ☐ No
6. Within the past ten years, have you ever:
   a. Used marijuana, cocaine, barbiturates, tranquilizers, heroin, LSD, amphetamines, morphine, narcotics; or any other drug, except as legally prescribed by a physician? ☐ Yes ☐ No
   b. Sought or received medical treatment or professional advice; or been arrested for the use of alcohol, cocaine, marijuana, narcotics or any other drug? . . . . ☐ Yes ☐ No
   c. Consumed alcoholic beverages? If yes, specify extent. ☐ Yes ☐ No
7. Have you been diagnosed by a licensed medical professional as having Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV)? . . . . ☐ Yes ☐ No
8. Have any of your immediate family members (parents, brothers and sisters), died of or been diagnosed as having; coronary artery disease, diabetes, cancer, stroke or kidney disease, prior to age 60? . . . . ☐ Yes ☐ No

	Age if Living	Cause of Death	Age at Death
Father:			
Mother:			
Brothers & Sisters			

9. a. Name and address of personal or attending physician:
   ____
   ____
   b. Telephone: ______________________________
   c. Date last consulted: ______________________________
   Reason and any medication/treatment given:
   ____
   d. List any medications *(prescription or nonprescription)* you are taking currently:
   ____
   ____

For each "Yes" answer, give details. (Identify: question number, diagnoses, dates, duration, names and addresses of all attending physicians and medical facilities. Attach additional sheet if needed.)

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

Dated at: ______________________________
City State Month Day Year

Signature of Proposed Insured: ______________________________

Witness: ______________________________
(Must be Examiner)

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

MEDICAL EXAMINER'S REPORT

1. a.

Height (in shoes)	Weight (clothed)	Chest (full inspiration)	Chest (forced Expiration)	Abdomen at Umbilicus
___ ft. ___ in.	_______ lbs.	_______ in.	_______ in.	_______ in.

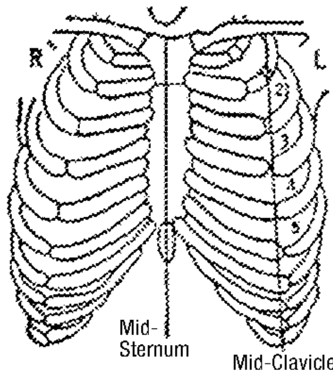
b. Did you weigh? ☐ Yes ☐ No Did you measure? ☐ Yes ☐ No

2. Blood Pressure (record ALL readings):

	At Rest	After Exercise	3 Minutes Later
Systolic			
4th phase			
Diastolic			
5th phase			
3. Pulse: Rate			
Irregularities			

4. Heart: Is there any:
Enlargement. . . ☐ Yes ☐ No Dyspnea . . . . ☐ Yes ☐ No
Murmer(s) . . . . ☐ Yes ☐ No Edema . . . . . ☐ Yes ☐ No
(Describe below. If more than one, describe separately.)

Location		
Constant	☐	☐
Inconstant	☐	☐
Transmitted	☐	☐
Localized	☐	☐
Systolic	☐	☐
Presystolic	☐	☐
Diastolic	☐	☐
Soft (Gr. 1-2)	☐	☐
Mod (Gr. 3-4)	☐	☐
Loud (Gr. 5-6)	☐	☐
After exercise:		
Increased	☐	☐
Absent	☐	☐
Unchanged	☐	☐
Decreased	☐	☐



Indicate:
Apex by **X** Point of greatest interest by ◯
Murmer area by ◌ Transmission by ➔
Please record your comments or impressions.

5. Is there on examination any abnormality of the following:
(Circle applicable items and give details.)
a. Eyes, ears, nose, mouth, pharynx? . . . . ☐ Yes ☐ No
(If vision or hearing markedly impaired, indicate degree and correction.)
b. Skin (incl. scars); lymph nodes; varicose veins or peripheral arteries? ☐ Yes ☐ No
c. Nervous system (include reflexes, gait, paralysis)? . . . . ☐ Yes ☐ No
d. Respiratory system? . . . . ☐ Yes ☐ No
e. Abdomen (include scars)? . . . . ☐ Yes ☐ No
f. Genitourinary system? . . . . ☐ Yes ☐ No
g. Endocrine system (include thyroid and breasts)? . . . . ☐ Yes ☐ No
h. Musculoskeletal system (include spine, joints, amputations, deformities)? ☐ Yes ☐ No

6. Are there any hernias? . . . . ☐ Yes ☐ No
7. Are you aware of additional medical history? . . . . ☐ Yes ☐ No
(A confidential report may be sent to the Medical Director)
8. Is appearance unhealthy or older than stated age? . . . . ☐ Yes ☐ No
9. Has the applicant used any form of tobacco within the past 24 months? ☐ Yes ☐ No
Indicate: ☐ Cigarettes ☐ Cigar ☐ Pipe ☐ Chew or "Smokeless"

10. How long and how well have you known the applicant?
____
____

11. Urinalysis

Albumin	Sugar	Blood

Have you mailed the urine specimen? ☐ Yes ☐ No

Specimen must be mailed in UNIFI mailer if any of the following factors apply:
1. Age 60 or over.
2. Amount of life insurance is $100,000 or more.
3. Current blood pressure reading over 140/90.
4. Albumin, sugar or occult blood is present in the urine test completed.
5. History of or findings of overweight, elevated blood pressure, cardiovascular or genitourinary disease or diabetes mellitus.
6. Either parent, or a brother or sister has or had diabetes.

Details of "Yes" answers. (Identify item.)

Examined at: ☐ applicant's residence on: ______________________ , year _______ , at: ___________ ☐ a.m. ☐ p.m.
☐ applicant's business
☐ examiner's office Signature of Examiner: ______________________ ☐ M.D. or ☐ D.O. ☐ Paramedic

Examiner's Social Security Number or Taxpayer Identification Number: ______________ Examiner's Address: ______________________

At request of: ______________________ (Producer) Agency Address: ______________________

UNIFI®
Companies

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, or tobacco, HIV, AIDS and sexually transmitted diseases, prescription drug records, financial status, education records, employment status or other relevant data or facts about the proposed insured or claimant; including wage and earnings, or data or facts with respect to other insurance coverage; to give all data or facts to the companies listed above ("the Companies"), their reinsurers, or any other agent or agency acting on the Companies' behalf.

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

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

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

Dated at: ______________________________
City State Month Day Year

____
Print or Type Name of Proposed Insured

X ______________________________
Signature of Proposed Insured

____
Print or Type Name of Other Proposed Insured

X ______________________________
Signature of Other Proposed Insured

____
Print or Type Name of Personal Representative of Proposed Insured

X ______________________________
Signature of Personal Representative of Proposed Insured

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

This Authorization complies with the HIPAA Privacy Rules.

Ameritas Life, Acacia Life, Union Central Life
and affiliated companies

Mature Assessment Limited

Insurance Company:________________________________***Policy Number:***______________________

Name of Proposed Insured:____

Date: ___________________

Name of Examiner: ____

Instruction For Examiner: This supplement is required on older aged applicants and is to be completed in addition to the usual requirements.

The Senior Supplement includes:

1. Get Up and Go Test
2. Activities of daily living section

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1. GET UP AND GO TEST

TIMED GET UP AND GO TEST

Time the number of seconds it takes for the applicant to sit and rise from a chair, walls 8 feet and return to the chair and sit back down. Timing should begin when the applicant begins standing up from a chair and ends when sitting back down. __________seconds

---

2. ACTIVITIES OF DAILY LIVING

A) What is the highest level of education you have completed? *(check one)*

- ☐ Advanced college degree ☐ College degree
- ☐ High School ☐ Did not complete high school

B) Which of these household activities do you perform regularly? *(check all that apply)*

- ☐ Cleaning ☐ Lawn mowing
- ☐ Laundry ☐ Shopping
- ☐ Meal preparation ☐ Handling finances
- ☐ Using a computer

C) Do you need help with any of the following? *(check all that apply)*

- ☐ Cooking ☐ Cleaning ☐ Laundry ☐ Shopping
- ☐ Banking ☐ Taking Medications ☐ Making phone calls

D) Have you had any falls in the past 3 years? ☐ Yes ☐ No

If yes, how many falls in the **past year**________

Give details and dates in the remarks section below. *(If needed use the addendum page)*

____

____

____

Ameritas Life, Acacia Life, Union Central Life
and affiliated companies

Mature Assessment Limited

Insurance Company: ______________________ ***Policy Number:*** ______________

Name of Proposed Insured: ______________________

2. ACTIVITIES OF DAILY LIVING (Continued)

E) Do you exercise? ☐ Yes ☐ No
If yes, what type of exercise and how often (x times/day - x-times/week - x-times/month)

____

____

F) Are you self-employed, a homemaker, or living off your own earnings? ☐ Yes ☐ No
If yes, how many hours do you work per week? _______ hours

G) Do you participate in any of the following (check all that apply)?
☐ Hobbies ☐ Volunteer work ☐ Other outside activities
If yes, explain and indicate the number of hours you participate each week

____

____

____

H) Do you travel? ☐ Yes ☐ No
If yes, give details including the average numbers of times each year, date and destination of last trip, and your travel plans for the next 12 months.

____

____

I) Do you currently drive? ☐ Yes ☐ No
If no, when and why did you stop?
If yes, give the number of miles driven per week and number of accidents in past 2 years

____

____

J) Do you own any pets? ☐ Yes ☐ No
If yes, what kind of pets do you own?

____

____

K) Are there other persons living in your household? ☐ Yes ☐ No
If yes, please indicate how many adults ______ and how many children

____

____

L) Where do you live now? *(house, apartment, etc.)*

____

____

M) If you could not afford to live alone where you do now, who would you prefer to live with? *(family member, assisted care facility, etc.)*

____

____

Ameritas Life, Acacia Life, Union Central Life
and affiliated companies

Mature Assessment Limited

Insurance Company:______________________________ ***Policy Number:***______________________

Name of Proposed Insured:____

EXAMINER OBSERVATIONS

You, as the examiner, play a vital role in giving your general observations, so that a clear picture maybe obtained of this person's physical and cognitive abilities. Any observations you make will be taken seriously. Please be honest in the following observations.

1. What is the person's general affect (cheerful, depressed, tired, etc.) ____________________
2. Does he/she have difficulty walking, sitting, rising? ____ Yes ____ No
3. Is there difficulty with understanding directions? ____ Yes ____ No
4. If a friend or relative accompanies this person, does the applicant seem to rely on that person for physical help or in following directions? ____ Yes ____ No
5. How is the applicant dressed (neatly, sloppily, etc.)? ____________________
6. Are there other observations you would like to make?

____
____
____
____
____

Remarks

Signature of Examiner ____ Date________________