Part II – Medical

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

Proposed Insured: _____ Birth Date: _____
Month Day Year

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

1. a) Height: ___ ft. ___ in. b) Weight: _____ lbs.
   c) Has your weight changed by more than 10 lbs. in the last twelve months? If yes, list amount gained or lost and reason for the change in weight. ☐ Yes ☐ No
2. Have you ever been medically evaluated for, diagnosed with or treated for:
   a) High blood pressure or high cholesterol levels? ☐ Yes ☐ No
   b) Disorder of the eyes, ears, nose or throat? ☐ Yes ☐ No
   c) Dizziness, vertigo, fainting, seizures, recurrent headache; speech defect, tremor, neuropathy, paralysis, multiple sclerosis, stroke, transient ischemic attack (TIA), memory loss, dementia or any other disorder of the brain or nervous system? ☐ Yes ☐ No
   d) Shortness of breath, chronic cough, bronchitis, asthma, emphysema, chronic obstructive pulmonary disease (COPD), sleep apnea, or chronic respiratory disorder? ☐ Yes ☐ No
   e) Chest pain, irregular heartbeat, heart murmur, heart valve disease, heart attack, coronary artery disease, heart failure, aneurysm or other disorder of the heart or blood vessels? ☐ Yes ☐ No
   f) Intestinal bleeding, inflammatory bowel disease (including Crohn's disease or ulcerative colitis), hepatitis, diverticulitis, recurrent indigestion or other disorder of the esophagus, stomach, intestines, pancreas, liver or gallbladder? ☐ Yes ☐ No
   g) Sugar, protein, or blood in urine; sexually transmitted disease (excluding HIV); chronic kidney disease, kidney stone or other disorder of the kidneys or bladder? ☐ Yes ☐ No
   h) Diabetes, elevated blood sugar, thyroid, pituitary, adrenal or other endocrine (glandular) disorders? ☐ Yes ☐ No
   i) Disorder of the breasts, reproductive organs, or prostate? ☐ Yes ☐ No
   j) C-section, miscarriage, or complication of pregnancy? ☐ Yes ☐ No
   k) Arthritis, gout, lupus or disorder of or injury to the bones, muscles, wrists, hips, knees or other joints? ☐ Yes ☐ No
   l) Spinal, neck or back disorder or injury, including sprains, strains, or disc disorder? ☐ Yes ☐ No
   m) Mass, polyp, cyst, tumor or cancer? ☐ Yes ☐ No
   n) Allergies; disorder of the skin; anemia, bleeding, clotting or other disorder of the blood? ☐ Yes ☐ No
   o) Anxiety, depression, stress, attention deficit hyperactivity disorder (ADHD), eating disorder or other psychiatric or mental health disorder? ☐ Yes ☐ No
   p) Chronic fatigue, chronic pain, fibromyalgia, or fever of unknown cause? ☐ Yes ☐ No
3. Are you currently pregnant? If yes, list expected due date. ☐ Yes ☐ No
4. Other than noted above, have you within the past five years:
   a) Consulted or received treatment from a chiropractor? ☐ Yes ☐ No
   b) Had a checkup, consultation, illness, injury, or surgery; been a patient in a hospital, rehabilitation center or other medical facility; had an X-ray, EKG, heart scan, MRI or CT scan, biopsy or other diagnostic test (excluding HIV)? ☐ Yes ☐ No
   c) Been advised by a licensed medical professional to have any diagnostic test (excluding HIV), hospitalization, or surgery which has not been completed? ☐ Yes ☐ No
5. Within the past ten years, have you ever:
   a) Used marijuana, cocaine, heroin, barbiturates, tranquilizers, hallucinogens, amphetamines, narcotics or any other drug, except as legally prescribed by a physician? ☐ Yes ☐ No
   b) Sought, received or been advised to seek medical treatment, counseling or participation in a support group for the use of alcohol or drugs? ☐ Yes ☐ No
   c) Consumed alcoholic beverages? If yes, specify extent. ☐ Yes ☐ No
6. Have you been diagnosed by a licensed medical professional as having Acquired Immune Deficiency Syndrome (AIDS) or ever tested positive for Human Immunodeficiency Virus (HIV)? ☐ Yes ☐ No
7. Have you or your immediate family members (parents, brothers and sisters) died of or been diagnosed as having coronary artery disease, stroke, diabetes, cancer, polycystic kidney disease or Huntington's disease prior to age 60? ☐ Yes ☐ No
8. Family History:

	Age if Living	Age at Death	Cause of 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 currently are taking:

For each "Yes" answer, give details. *(identify: question number, diagnosis, dates, duration, treatment, names and addresses of all attending physicians and medical facilities and 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 Company on this application and the initial application *(UN 2550, et al.)*.

Dated at: _____ Signature of Proposed Insured: _____
City State Month Day Year

Signature of Witness: _____ Signature of Parent or Guardian: _____
Must be Examiner If Proposed Insured is under age 18

Medical Examiner's Report

1. a. Height (in shoes) ___ ft. ___ in. | Weight (clothed) _____ lbs. | Chest (full inspiration) _____ in. | Chest (forced Expiration) _____ in. | Abdomen at Umbilicus _____ in.

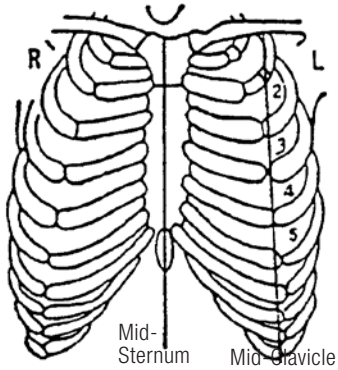
   b. Did you weigh? ☐ Yes ☐ No Did you measure? ☐ Yes ☐ No

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 Company 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 ☐ applicant's business ☐ examiner's office on: _____ , year _____ , at: _____ ☐ a.m. ☐ p.m.

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: _____

Part II – Medical

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Authorization

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

Authorization to Obtain and Disclose Information

I authorize any health care providers, pharmacy benefit manager, hospitals, insurers, MIB, 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, or 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 Company, its reinsurers, or any other agent or agency acting on the Company's behalf.

I authorize the Company, or its reinsurers, to disclose data or facts obtained, including Protected Health Information, to the MIB. Data or facts obtained will be released only: (1) to reinsurers; (2) to the MIB; (3) to persons performing business duties as directed or contracted for by the Company 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. I acknowledge and agree that the personal data or facts used or disclosed under this authorization may be subject to redisclosure and no longer protected by federal privacy regulations.

I acknowledge and agree that 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 materially 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 Company; (2) revoking this authorization will not affect any prior action taken by the Company in reliance upon this authorization; and (3) failing to sign, or revoking this authorization may impair the Company's 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 Proposed Insured Name

X _____
Signature of Proposed Insured

_____
Print or Type Other Proposed Insured Name

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)