AMERITAS LIFE INSURANCE CORP. OF NEW YORK
A UNIFI Company

Disability Income

Occupation and Financial Details

Ameritas Life Insurance Corp. of New York
P.O. Box 40888, Cincinnati, OH 45240
877-280-6110, Fax 513-595-2352
(Client Service Office)

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, if greater than $20,000 *(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 group or individual disability insurance in force, or for which you will become eligible in the next year, or applications currently pending? ☐ Yes ☐ No

b) If "Yes," list coverage details in the following table. *(For type of coverage, indicate as: group, individual, 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 Ameritas Life of NY 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 Business 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, partners or employees in your profession.)*

Rent/Lease:	$ _____
Utilities:	$ _____
Telephone:	$ _____
Depreciation:	$ _____
Liability Insurance:	$ _____
Property Taxes:	$ _____
Salaries:	$ _____
Mortgage Interest:	$ _____
Payroll Taxes:	$ _____
Employee Benefits:	$ _____
Other:	$ _____

d) Salaries of partners or employees in your profession:
$_____

e) If you are reimbursed in any manner for any of the above expenses, provide complete details: _____
_____
_____