

Application for Insurance Personal Information

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. Proposed Insured (One):		2. Owner Information (One):	
a)	Name:		mplete only if Owner is other than Proposed Insured.)
b)) Date of Birth: c) Sex:	,	☐ Individual b) ☐ Trust (provide copy) c) ☐ Partnership
d)	Place of Birth:	,	Corporation: County of Incorporation:
f)) Social Security/Tax ID No.: Driver's License or other Government issued picture ID:	e)	Pull Name:
		f)	
	State:	g)	Trustee(s) Name:
	Home Address:	h)	Date of Birth or Date of Trust:
3/	City: State: ZIP:	i)	Social Security/Tax ID No.:
h)	Years at this Address:	j)	Driver's License or other Government issued picture ID:
			State:
i)	- (k)	Address:
	(Business):		City: State: ZIP:
	Fax:	l)	Tel. (Home):
	E-mail:		(Business):
	Best time to call: at: Dusiness Home In the event you are not available when our		Fax:
	interviewer calls, may we speak with your spouse? Yes No		E-mail:
j) k)	Residency Status: U.S. Resident Other: Other: Yes No If "No," complete Foreign National form UN 0918 and provide the following:		n) Residency Status: U.S. Resident Other:
		n)	Are you a U.S. Citizen: If "No," complete Foreign National form UN 0918 and provide the following:
	Citizenship:		Citizenship:
	Visa Type: Visa #:		Visa Type: Visa #:
I)	Employer Name:		Multiple Ownership (indicate type):
	Address:	0)	☐ Joint with Survivorship ☐ Tenants in Common
	City:State:ZIP:	p)	Successor Owner:
m)	Occupation: Years:	• ,	Name:
	Duties:		Social Security/Tax ID No.:
3. Be	eneficiary Information: (Subject to change by Owner.)		
	Primary Beneficiary:	b)	Contingent Beneficiary:
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	Address:		Address:
	City:State: ZIP:		City: State: ZIP:
	Relationship to Proposed Insured:		Relationship to Proposed Insured:
	Social Security/Tax ID:		Social Security/Tax ID:
	Date of Birth or Date of Trust:		Date of Birth or Date of Trust:



Application for Insurance Personal Information (continued)

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(Client Service Office)

1. Pr	oposed Insured (Two):	2. Owner Information (Two):
a)	Name:	(Complete only if Owner is other than Proposed Insured.)
b)	Date of Birth: c) Sex:	a) Individual b) Trust (provide copy) c) Partnership
d)	Place of Birth:	d) Corporation: County of Incorporation:
•	Social Security/Tax ID No.: Driver's License or other Government issued picture ID:	e) Full Name:
		f) Relationship to Proposed Insured(s):
	State:	g) Trustee(s) Name:
g)	Home Address:	h) Date of Birth or Date of Trust:
-	City:State: ZIP:	i) Social Security/Tax ID No.:
h)	Years at this Address:	j) Driver's License or other Government issued picture ID:
	Tel. (Home):	State:
,	(Business):	k) Address:
	Fax:	City:State: ZIP:
	E-mail:	l) Tel. (Home):
	Best time to call: at: _ Business _ Home	(Business):
	In the event you are not available when our	Fax:
	interviewer calls, may we speak with your spouse? Yes No	E-mail:
j)	Residency Status: U.S. Resident Other:	m) 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:	n) Are you a U.S. Citizen: Yes No If "No," complete Foreign National form UN 0918 and provide the following:
	Citizenship:	Citizenship:
	Visa Type: Visa #:	Visa Type: Visa #:
l)	Employer Name:	o) Multiple Ownership (indicate type):
	Address:	☐ Joint with Survivorship ☐ Tenants in Common
	City:State: ZIP:	p) Successor Owner:
m)	Occupation: Years:	Name:
n)	Duties:	Social Security/Tax ID No.:
3. Pr	oposed Insured: (Child One or Other.)	4. Proposed Insured: (Child Two or Other.)
a)	Name:	a) Name:
	Relationship:	b) Relationship:
c)	Date of Birth: d) Sex: Male Female	c) Date of Birth: d) Sex: Male Female
e)	Place of Birth:	e) Place of Birth:
	Social Security No:	f) Social Security No:
	Ins. in Force/Company:	g) Ins. in Force/Company:
	Driver's License No:	h) Driver's License No:
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