AMERITAS LIFE INSURANCE CORP. OF NEW YORK
A UNIFI Company

Disability Income
Policy 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. Individual Disability Income Insurance:

a) Contract Type
- ☐ Noncancelable and Guaranteed Renewable (5501-NC)
- ☐ Guaranteed Renewable (5502-GR)

b) Definition of Disability
- ☐ Own Occ for benefit period (OO)
- ☐ Own Occ and Not Working for benefit period (NW)
- ☐ 60 month Own Occ and Not Working thereafter (ON)

c) Base Monthly Benefit: $ _____

d) Elimination Period *(Days)*:
☐ 30 ☐ 60 ☐ 90 ☐ 180 ☐ 365 ☐ 730

e) Benefit Period:
☐ 1 Year ☐ 2 Years ☐ 5 Years ☐ 10 Years
☐ To Age 65 ☐ To Age 67 ☐ To Age 70

f) Riders:
- ☐ Enhanced Residual Disability Rider
- ☐ Basic Residual Disability Rider
- ☐ Cost of Living Adjustment Rider – 6% Compound
- ☐ Cost of Living Adjustment Rider – 3% Simple
- ☐ Social Insurance Substitute Rider:
  Amount: $ _____ Elimination Period *(Days)*:_____
- ☐ Catastrophic Disability Rider:
  Amount: $ _____ Elimination Period *(Days)*:_____
  Benefit Period *(Years)*: _____
- ☐ Future Increase Option Rider: Amount: $_____
- ☐ Automatic Increase Rider
- ☐ Other:_____

g) Do you understand and agree that under the terms of the Individual Disability Income policy applied for, no monthly benefit is payable during the elimination period of any disability? ☐ Yes ☐ No

2. Business Overhead Expense (5503-BOE):

a) Maximum Base Monthly Benefit: $ _____

b) Elimination Period *(Days)*:
☐ 30 ☐ 60 ☐ 90

c) Benefit Period *(Months)*:
☐ 12 ☐ 18 ☐ 24

d) Riders:
- ☐ Future Increase Option Rider: Amount: $ _____
- ☐ Substitute Salary Expense Rider: Amount: $ _____

e) Do you understand and agree that under the terms of the Business Overhead Expense policy applied for, no monthly benefit is payable during the elimination period of any disability? ☐ Yes ☐ No

3. Premium:

a) Premium Payor:
☐ Insured ☐ Employer ☐ Other: _____

b) Send Premium Notices to:
☐ Residence ☐ Business
☐ Other *(specific relationship and address):*
_____

c) Premium Frequency:
- ☐ Annual
- ☐ Semi-Annual
- ☐ Quarterly
- ☐ Step Rate
- ☐ Electronic Funds Transfer *(complete EFT form)*
- ☐ Salary Allotment/List Bill
  List bill number: _____
- ☐ Other:_____

d) Association Discount: ☐ Yes ☐ No *(If "Yes," give IPN.)*
Association IPN: _____

e) 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.)

Individual Disability Income: $_____
Business Overhead Expense: $_____
Total: $_____

4. Business Ownership:

a) Do you have any ownership in the business where you work?
☐ Yes ☐ No If "Yes," what percent do you own?_____%

b) If "Yes," what type of business is it?
☐ C-Corp ☐ S-Corp ☐ LLP
☐ LLC ☐ Partnership ☐ Sole Proprietor
☐ Other:_____

c) If "Yes," how many other owners or partners are there? ___

5. Occupation / Employment:

a) How many total employees are there in the business where you work? _____

b) How long have you been employed at the business where you work? _____

c) How many hours per week do you work in your primary occupation? _____

d) How long have you worked in your primary occupation? _____

e) Do you have any other occupations not listed elsewhere on this application? ☐ Yes ☐ No
(If "Yes," give details, including description of duties and hours worked per week.)
_____
_____

f) If this application is for Individual Disability Income Insurance, will your employer pay the premium for this coverage? ☐ Yes ☐ No

g) If "Yes," what percentage will be paid by the employer?__%

h) If "Yes," will the premium paid by the employer be included in your taxable income? ☐ Yes ☐ No

i) Have you ever had a professional license suspended or revoked; or is such license under review; or have you been disbarred? ☐ Yes ☐ No
(If "Yes," give details.)
_____