

SERFF Tracking Number: UNNC-125710473 State: Arkansas
Filing Company: Acacia Life Insurance Company State Tracking Number: 39418
Company Tracking Number: UN 1767
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: UNIFI Supplemental Applications-ACLIC
Project Name/Number: UNIFI Supplemental Applications/UN 1767, et al

Filing at a Glance

Company: Acacia Life Insurance Company

Product Name: UNIFI Supplemental Applications-ACLIC

TOI: L08 Life - Other

Sub-TOI: L08.000 Life - Other

Filing Type: Form

SERFF Tr Num: UNNC-125710473 State: ArkansasLH

SERFF Status: Closed

Co Tr Num: UN 1767

Co Status:

Authors: Bobbie Cramer, Joanne Friend, Tanya Garrett

Date Submitted: 06/25/2008

State Tr Num: 39418

State Status: Approved-Closed

Reviewer(s): Linda Bird

Disposition Date: 07/14/2008

Disposition Status: Approved

Implementation Date:

Implementation Date Requested: On Approval

State Filing Description:

General Information

Project Name: UNIFI Supplemental Applications

Project Number: UN 1767, et al

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 07/14/2008

State Status Changed: 07/14/2008

Corresponding Filing Tracking Number:

Filing Description:

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Individual

Group Market Size:

Group Market Type:

Deemer Date:

Re: The Union Central Life Insurance Company NAIC No. 80837-394 FEIN No. 31-0472910

Acacia Life Insurance Company NAIC No. 60038-394 FEIN No. 53-0022880

Ameritas Life Insurance Corp. NAIC No. 61301-394 FEIN No. 47-0098400

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Submission Form Identification: UN 1767 , et al. (See attached Exhibit A)

Designation of form as Individual or Group Market: Individual

Enclosed for your review and approval are the individual Supplemental Application forms listed on the attached Exhibit A, which we are updating and revising the format for a multi-company approach. These Supplemental Applications will be used by the three UNIFI companies of Acacia Life Insurance Company, Ameritas Life Insurance Corporation, and The Union Central Life Insurance Company for all individual life product lines. Form UN 1799 will also be used with Union Central Life's individual disability income portfolio. We are submitting these are three separate filings for each company simultaneously.

The client will be asked to check a box on the first page of each form to indicate the Company for which they are completing the form. They will always be used in conjunction with our previously approved base application, UN 2550 PI-A, et al.

Exhibit A lists each form, its flesch score, and whether or not it is replacing an existing form. The flesch scores listed exclude medical terminology, federally or state required language. No part of this filing contains any unusual or possibly controversial items from normal company or industry standards.

If you have any questions or comments regarding this filing, please refer them to me at 1-800-825-1551, extension 52329, (email address: bcramer@unioncentral.com). Thank you for your consideration of this submission. Be assured it is appreciated.

Company and Contact

Filing Contact Information

Bobbie Cramer, Sr. Contract Analyst
1876 Waycross Road
Cincinnati, OH 45240

bcramer@unioncentral.com
(513) 595-2329 [Phone]

Filing Company Information

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Acacia Life Insurance Company CoCode: 60038 State of Domicile: District of
Columbia
7315 Wisconsin Avenue Group Code: 943 Company Type: Stock
Bethesda, MD 20814 Group Name: State ID Number:
(800) 825-1551 ext. [Phone] FEIN Number: 53-0022880

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Filing Fees

Fee Required? No
Retaliatory? No
Fee Explanation:
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Acacia Life Insurance Company	\$0.00	06/25/2008	

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Linda Bird	07/14/2008	07/14/2008

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending	Linda Bird	06/26/2008	06/26/2008	Bobbie Cramer	07/08/2008	07/08/2008
Industry Response						

Amendments

Item	Schedule	Created By	Created On	Date Submitted
Exhibit A & B	Supporting Document	Bobbie Cramer	06/25/2008	06/25/2008

SERFF Tracking Number: UNNC-125710473 *State:* Arkansas
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Disposition

Disposition Date: 07/14/2008

Implementation Date:

Status: Approved

Comment:

Rate data does NOT apply to filing.

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Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice		Yes
Supporting Document	Application		No
Supporting Document	Exhibit A & B		Yes
Form	Application for Life Reinstatement		Yes
Form	Application for Change of Coverage		Yes
Form	Part II - Non Medical Application		Yes
Form	Part II - Medical Application		Yes
Form	Application to Exercise Option to Purchase Additional Insurance		Yes
Form	Application for Policy Change		Yes

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Objection Letter

Objection Letter Status Pending Industry Response

Objection Letter Date 06/26/2008

Submitted Date 06/26/2008

Respond By Date

Dear Bobbie Cramer,

This will acknowledge receipt of the captioned filing.

Objection 1

- Certification/Notice (Supporting Document)
- Application (Supporting Document)
- Application for Life Reinstatement (Form)
- Application for Change of Coverage (Form)
- Part II - Non Medical Application (Form)
- Part II - Medical Application (Form)
- Application to Exercise Option to Purchase Additional Insurance (Form)
- Application for Policy Change (Form)
- Exhibit A & B (Supporting Document)

Comment: The filing fee was included under EFT on this submission. Please advise if a check for the filing fee will follow by regular mail on this filing? We will hold your filing in a pending status until the fee is received.

Please feel free to contact me if you have questions.

Sincerely,

Linda Bird

Response Letter

Response Letter Status Submitted to State

Response Letter Date 07/08/2008

Submitted Date 07/08/2008

Dear Linda Bird,

Comments:

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Response 1

Comments: I'm mailing the check in the amount of \$120.00 today (\$20/form x 6 forms = \$120.00). The check # is 02034764.

Related Objection 1

Applies To:

- Certification/Notice (Supporting Document)
- Application (Supporting Document)
- Application for Life Reinstatement (Form)
- Application for Change of Coverage (Form)
- Part II - Non Medical Application (Form)
- Part II - Medical Application (Form)
- Application to Exercise Option to Purchase Additional Insurance (Form)
- Application for Policy Change (Form)
- Exhibit A & B (Supporting Document)

Comment:

The filing fee was included under EFT on this submission. Please advise if a check for the filing fee will follow by regular mail on this filing? We will hold your filing in a pending status until the fee is received.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Sincerely,

Bobbie Cramer, Joanne Friend, Tanya Garrett

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Amendment Letter

Amendment Date:

Submitted Date: 06/25/2008

Comments:

Exhibit A & B

Changed Items:

Supporting Document Schedule Item Changes:

User Added -Name: Exhibit A & B

Comment:

EXHIBIT A.pdf

EXHIBIT B - App descripts.pdf

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Form Schedule

Lead Form Number: UN 1767

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	UN 1767	Application/ Enrollment Form	Application for Life Reinstatement	Initial		79	UN 1767.pdf
	UN 1799	Application/ Enrollment Form	Application for Change of Coverage	Initial		56	UN 1799.pdf
	UN 2597	Application/ Enrollment Form	Part II - Non Medical Application	Initial		84	UN 2597.pdf
	UN 2598	Application/ Enrollment Form	Part II - Medical Application	Initial		81	UN 2598.pdf
	UN 2611	Application/ Enrollment Form	Application to Exercise Option to Purchase Additional Insurance	Initial		51	UN 2611.pdf
	UN 2852 B	Application/ Enrollment Form	Application for Policy Change	Initial		51	UN 2852 B.pdf

Of Policy Number(s): _____

CHECK ALL COMPANIES THAT APPLY:

- 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

Insured: _____ Home Telephone No.:(_____) _____

The representations made below apply to **EACH PERSON** who would be insured under this policy, if reinstated: The **INSURED** and **CHILDREN** of the **INSURED**, if applicable.

IMPORTANT: To apply for reinstatement, **Questions 1, 2, 3, 4, and 5 must be answered for all policies and details of all "Yes" answers must be provided.**

	Primary Ins.:		Other Ins.:		Children:	
	Yes	No	Yes	No	Yes	No
Within the past five years has any person who would be insured under this policy (applies to Questions 1, 2, and 3 only):						
1. a. Applied for insurance or reinstatement which was: declined, postponed, rated, modified; or had any such insurance canceled or a renewal premium refused?	<input type="checkbox"/>					
b. Received or claimed: indemnity, benefits, or a payment for any injury, sickness or impaired condition?	<input type="checkbox"/>					
c. Engaged in or plan to engage in any form of: motorized racing, scuba diving, parachuting, sky diving, hang-gliding, ballooning, mountain climbing, rodeos or competitive skiing?	<input type="checkbox"/>					
d. Made any flights as: a pilot, student pilot, or crew member of any aircraft or intend doing so?	<input type="checkbox"/>					
e. Been charged or convicted of or currently awaiting trial on the violation of any criminal law; fined more than \$50 for the violation of any traffic law, or had driver's license suspended? . .	<input type="checkbox"/>					
2. Been in a hospital, clinic, or institution for: examination, observation, diagnosis, operation, or treatment?	<input type="checkbox"/>					
3. In addition to any information listed above; have you within the past five years consulted or been treated or examined by a licensed medical professional?	<input type="checkbox"/>					
4. Have you been diagnosed by a licensed medical professional as having Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV)?	<input type="checkbox"/>					
5. Is anyone now under observation or receiving medical treatment from a licensed medical professional?	<input type="checkbox"/>					

Give DETAILS of all "YES," answers for Questions 1, 2, 3, 4 and 5. Specify name of person, disease or injury, dates, results of treatment, names and addresses of each doctor and each hospital. (Use reverse side if additional space is needed.)

6. TOBACCO USE:
Complete for all persons proposed for coverage age 18 or over.

	Smoke Cigarettes or Use Tobacco?	Formerly Smoked Cigarettes or Used Tobacco?	If "Yes," List Type of Tobacco, Date and Reason Discontinued:
Name: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Name: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

"You" and "your" mean the Policyowner and the Insured, if other than the Policyowner. "We," "us," "our" mean The UNIFI Companies.

The undersigned has reviewed and understands the applicable fraud warning statement on the next page.

Dated at: _____, Month: _____ Day: _____, Year: _____.

Witness. _____ Signature of Insured (always required).

Signature of Policyowner.



Application for Life Reinstatement Fraud Notice

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

Unless specific state language is noted below, the following general fraud notice applies.

FRAUD NOTICE

Any person who knowingly or with intent to defraud; submits an application or files a claim containing false, incomplete or misleading information; is guilty of a crime and may be subject to fines and criminal penalties, including imprisonment. In addition, insurance benefits may be denied if false information provided by an applicant is materially related to a claim.

CA, GA, KS, NE, VT and WA RESIDENTS

Any person who knowingly or with intent to defraud; submits an application or files a claim containing false, incomplete or misleading information; may be guilty of a crime and may be subject to fines and criminal penalties, including imprisonment. In addition, insurance benefits may be denied if false information provided by an applicant is materially related to a claim.

CO RESIDENTS

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

FL RESIDENTS

Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim or any application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

MA RESIDENTS

Any person who knowingly presents a false or fraudulent claim for payment of a loss of benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

ME RESIDENTS

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company.

NJ RESIDENTS

Any person who includes any false or misleading information on an application for an insurance policy is subject to civil and criminal penalties.

OR RESIDENTS

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

PA RESIDENTS

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any material false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

TX RESIDENTS

Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

VA RESIDENTS

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

Of Policy Number(s): _____

CHECK ALL COMPANIES THAT APPLY:

- 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
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800-319-6901, Fax 513-595-2218

FOR ALL APPLICATIONS - Questions Should be Answered.

1. ALL PERSONS PROPOSED FOR COVERAGE:

Full Name:	Relationship:	Sex:	Age:	Birth Date:	Place of Birth:	Ins. in Force or applied for:

2. EXISTING INSURANCE:

- a) Do you have any existing life insurance policies, disability income policies or annuity contracts? Yes No
(If "Yes," complete a Replacement Notice if required by State Law.)
- b) Will any life insurance, annuity, disability income or overhead expense insurance with this or any other company be discontinued, reduced, changed or replaced if insurance now applied for is issued? Yes No If "Yes," give details:

Company: _____ Policy No.: _____ Amount: \$ _____ Issue Date: _____

3. PRODUCER'S REPLACEMENT STATEMENT:

- a) Does the applicant have any existing life insurance policies, disability income policies or annuity contracts? Yes No
- b) To the best of your knowledge, does the policy applied for involve replacement, in whole or in part, of any existing life insurance, annuity contract, disability income or overhead expense insurance, or any other accident and sickness insurance? Yes No If "Yes," give details: Company: _____ Policy No.: _____

4. What prompted your request for change of coverage? _____

5. FOR DISABILITY INCOME (DI) PROVIDE:

- a) Employer name: _____ b) Occupation: _____
- c) Duties: _____
- d) Annual earned income: _____ Unearned income: _____
- e) DI in force (company, monthly benefit, benefit period, waiting period): _____

6. HAS ANY PERSON PROPOSED FOR COVERAGE:

	Yes	No	If "Yes," give details of a, b, c, e, f, g, h, and i, including name of person.
a) Used tobacco or nicotine products in any form within the last five years? (In Details, provide dates and type: cigarettes, cigars, cigarillos, a pipe, chewing tobacco, nicotine patches, gum, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	
b) Ever applied for insurance or reinstatement which was: declined, postponed, rated, modified; or had any such insurance canceled or a renewal premium refused? (In Details, provide date, reason, and company name.)	<input type="checkbox"/>	<input type="checkbox"/>	
c) Ever received or claimed: indemnity, benefits, or a payment for any injury, sickness or impaired condition?.	<input type="checkbox"/>	<input type="checkbox"/>	
d) Ever made any flights as: a pilot, student pilot, or crew member of any aircraft? (If "Yes," complete Aviation Questionnaire.)	<input type="checkbox"/>	<input type="checkbox"/>	
e) Been convicted of a moving traffic violation, had any traffic accidents, or had a driver's license revoked or suspended within the past five years? Driver's License Number: _____	<input type="checkbox"/>	<input type="checkbox"/>	
f) Been charged with or convicted of or currently awaiting trial on the violation of any criminal law?	<input type="checkbox"/>	<input type="checkbox"/>	
g) In the next year, any intention of traveling outside the U.S. or Canada, or residing outside the U.S.? (If "Yes," complete Foreign Travel Questionnaire.) . .	<input type="checkbox"/>	<input type="checkbox"/>	
h) Belong to or intend joining any active or reserve military, naval, or aeronautic organizations? (If "Yes," complete military questionnaire.)	<input type="checkbox"/>	<input type="checkbox"/>	
i) Engaged in or plan to engage in any form of: motorized racing, scuba diving, parachuting, sky diving, hang-gliding, ballooning, mountain climbing, rodeos or competitive skiing?	<input type="checkbox"/>	<input type="checkbox"/>	

"You" and "your" mean the Policyowner and the Insured, if other than the Policyowner, and the Other Insured. "We," "us," and "our" mean the UNIFI Companies.

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800-319-6901, Fax 513-595-2218

For Nonmedical applications on Insured, other Insured Persons and Children, or Applicant if Payor Benefits applied for - Questions Should be Answered.

	Proposed Insured:	Other Insured:	All Children:	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.)
5. Other than noted above, has anyone 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
b) Been advised by a licensed medical professional to have any diagnostic test, hospitalization, or surgery which was not completed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
6. Within the past ten years, has anyone proposed for coverage ever:				
a) Used marijuana, cocaine, barbiturates, tranquilizers, heroin, LSD, amphetamines, morphine, narcotics; or any other drug, except as legally prescribed by a physician?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
c) Consumed alcoholic beverages? If yes, specify extent?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
7. Has anyone proposed for coverage been diagnosed by a licensed medical professional as having Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
8. Have any 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Age if Living	Cause of Death	Age at Death	
Father:	_____	_____	_____	
Mother:	_____	_____	_____	
Brothers & Sisters:	_____	_____	_____	
9. a) Name and address of personal or attending physician(s):				

b) Telephone:	_____			
c) Date last consulted:	_____			
Reason and any medication/treatment given:	_____			

d) List any medications (prescription or nonprescription) you are taking currently:				



Application for Change of Coverage Fraud Notice

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

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CA, GA, KS, NE, VT and WA RESIDENTS

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CO RESIDENTS

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FL RESIDENTS

Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim or any application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

MA RESIDENTS

Any person who knowingly presents a false or fraudulent claim for payment of a loss of benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

ME RESIDENTS

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company.

NJ RESIDENTS

Any person who includes any false or misleading information on an application for an insurance policy is subject to civil and criminal penalties.

OR RESIDENTS

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

PA RESIDENTS

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any material false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

TX RESIDENTS

Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

VA RESIDENTS

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.



Application for Change of Coverage Agreement

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

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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

Agreement

The undersigned represent that their statements in this application and Part II, if such Part II is required by the companies listed above ("the Companies"), are true and complete to the best of their knowledge and belief. It is agreed that:

- (a) the only statements to be considered as the basis of the policy are those contained in the application or in any amendment to the application;
- (b) no one except the President, a Vice President, the Secretary, or an Assistant Secretary can make, alter or discharge contracts or waive any of the Companies' rights or requirements; and
- (c) this application was signed and dated in the state indicated.

Dated at: _____
 City State Month Day Year

Print or Type Proposed Insured Name.

X _____
Signature of Proposed Insured (always required).

Print or Type Name of Witness.

X _____
Signature of Witness.

Print or Type Name of Other Proposed Insured.

X _____
Signature of Other Proposed Insured.
(If other than policyowner and age 15 or over.)

Print or Type Name of Policyowner.

X _____
Signature of Policyowner.

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.

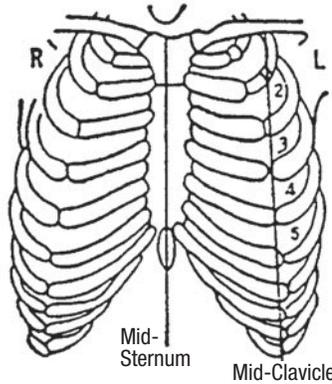
b. Did you weigh? Yes No Did you measure? Yes No

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
 Murmur(s) Yes No Edema Yes No
 (Describe below. If more than one, describe separately.)

Location		
Constant	<input type="checkbox"/>	<input type="checkbox"/>
Inconstant	<input type="checkbox"/>	<input type="checkbox"/>
Transmitted	<input type="checkbox"/>	<input type="checkbox"/>
Localized	<input type="checkbox"/>	<input type="checkbox"/>
Systolic	<input type="checkbox"/>	<input type="checkbox"/>
Presystolic	<input type="checkbox"/>	<input type="checkbox"/>
Diastolic	<input type="checkbox"/>	<input type="checkbox"/>
Soft (Gr. 1-2)	<input type="checkbox"/>	<input type="checkbox"/>
Mod (Gr. 3-4)	<input type="checkbox"/>	<input type="checkbox"/>
Loud ((Gr. 5-6)	<input type="checkbox"/>	<input type="checkbox"/>
After exercise:		
Increased	<input type="checkbox"/>	<input type="checkbox"/>
Absent	<input type="checkbox"/>	<input type="checkbox"/>
Unchanged	<input type="checkbox"/>	<input type="checkbox"/>
Decreased	<input type="checkbox"/>	<input type="checkbox"/>



Indicate:
 Apex by **X** Point of greatest interest by
 Murmur 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 periperal 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:
- Age 60 or over.
 - Amount of life insurance is \$100,000 or more.
 - Current blood pressure reading over 140/90.
 - Albumin, sugar or occult blood is present in the urine test completed.
 - History of or findings of overweight, elevated blood pressure, cardiovascular or genitourinary disease or diabetes mellitus.
 - 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 _____ Examiner's Address: _____
 or Taxpayer Identification Number: _____

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

CHECK ALL COMPANIES THAT APPLY:

- | | | |
|--|---|--|
| <input type="checkbox"/> Acacia Life Insurance Company
P.O. Box 81889, Lincoln, NE 68501
800-745-1112 Fax 402-467-7335
(Client Service Department) | <input type="checkbox"/> Ameritas Life Insurance Corp.
P.O. Box 81889, Lincoln, NE 68501
800-745-1112 Fax 402-467-7335 | <input type="checkbox"/> The Union Central Life Insurance Company
P.O. Box 40888, Cincinnati, OH 45240
800-319-6901, Fax 513-595-2218 |
|--|---|--|

1. Full Name of Proposed Insured (Please Print):
 First: _____ Middle: _____ Last: _____
2. Social Security No.: _____ 3. Birth Date: _____ 4. Birth Place: _____ 5. Age Last Birthday: _____
6. Residence Address: _____ City: _____
 County: _____ State: _____ Zip: _____ 7. Male Female
8. Plan of insurance: _____ Minimum: _____ and _____
 Maximum shown in policy: _____ (For Ameritas/Acacia, submit new application if changing policy plan.)
9. Disability premium waiver on proposed insured? Yes No
10. Accidental means death benefit: \$ _____ 11. Automatic premium loan? Yes No
12. Dividend Option: Paid-up additions Reduce premium (not on monthly mode) Cash Other: _____
13. Premium Mode: Annual Semiannual Quarterly Electronic Fund Transfer (Complete EFT form) Salary Allotment
 Other (Specify): _____
14. Send premium notices to (print): Full Name: _____
 Number and Street: _____
 City: _____ County: _____ State: _____ Zip Code: _____
15. Owner of policy (who may exercise all rights) to be: Insured Applicant if other than insured
 If other than insured or applicant, print full name and relationship to insured: _____
16. Social Security or Taxpayer identifying number: Owner: _____ Premium Payer: _____
17. Policy number of basic insurance policy to which the Guaranteed Insurability Option Rider is attached: Number: _____
18. What is the option date of the Guaranteed Insurability Option Rider as of which the additional insurance hereby applied for is to be purchased?
 Date: Month: _____ Day: _____ Year: _____
19. Primary beneficiary: _____ Relationship: _____ SSN#: _____
 Contingent beneficiary: _____ Relationship: _____ SSN#: _____
20. Existing Insurance:
 - a) Do you have any existing insurance policies or annuity contracts? Yes No
 (If "Yes," complete a Replacement Notice if required by State Law.)
 - b) Will any life insurance, annuity, disability income or overhead expense insurance with this or any other company be discontinued, reduced, changed or replaced if insurance now applied for is issued? Yes No If "Yes," give details:
 Company: _____ Policy No.: _____ Amount: \$ _____ Issue Date: _____
21. Producer's Replacement Statement:
 - a) Does the applicant have any existing life insurance policies or annuity contracts? Yes No
 - b) To the best of your knowledge, does the policy applied for involve replacement, in whole or in part, of any existing life insurance, annuity contract, disability income or overhead expense insurance, or any other accident and sickness insurance? Yes No
 If "Yes," give details: Company: _____ Policy No.: _____
22. 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: Check Cash Other: _____
 Life: \$ _____ Adjustable Life: P.P.P. _____ Lump Sum: \$ _____

It is agreed that this application is made for the purpose of exercising a right to purchase additional insurance granted under the Guaranteed Insurability Option Rider mentioned in Questions 17 and 18 above. It is further agreed that this application shall form a part of any contract issued by the Company checked above on the life of the proposed insured pursuant to such right.

Soliciting Producer _____	Producer No. _____	Soliciting Producer _____	Producer No. _____
State Lic. No.: _____		Producer Print or Type Name.: _____	
Dated at: City: _____		State: _____ Date: Month: _____ Day: _____ Year: _____	

Signature of Proposed Insured. _____ Signature of owner of basic policy. _____

If disability or accidental means death benefits are applied for and were not issued as a part of the basic policy to which the Guaranteed Insurability Option Rider is attached, evidence of insurability satisfactory to the Company checked above must be furnished. Please contact the Home Office for required forms.

Application to Exercise Option to Purchase Additional Insurance Fraud Notice

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

Unless specific state language is noted below, the following general fraud notice applies.

FRAUD NOTICE

Any person who knowingly or with intent to defraud; submits an application or files a claim containing false, incomplete or misleading information; is guilty of a crime and may be subject to fines and criminal penalties, including imprisonment. In addition, insurance benefits may be denied if false information provided by an applicant is materially related to a claim.

CA, GA, KS, NE, VT and WA RESIDENTS

Any person who knowingly or with intent to defraud; submits an application or files a claim containing false, incomplete or misleading information; may be guilty of a crime and may be subject to fines and criminal penalties, including imprisonment. In addition, insurance benefits may be denied if false information provided by an applicant is materially related to a claim.

CO RESIDENTS

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

FL RESIDENTS

Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim or any application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

MA RESIDENTS

Any person who knowingly presents a false or fraudulent claim for payment of a loss of benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

ME RESIDENTS

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company.

NJ RESIDENTS

Any person who includes any false or misleading information on an application for an insurance policy is subject to civil and criminal penalties.

OR RESIDENTS

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

PA RESIDENTS

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any material false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

TX RESIDENTS

Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

VA RESIDENTS

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

Application to Exercise Option to Purchase Additional Insurance

Conditional Receipt

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

DO NOT DETACH UNLESS PREMIUM PAYMENT IS MADE WHEN APPLICATION IS DATED AND SIGNED. DO NOT USE IF LIFE INSURANCE APPLIED FOR IS OVER \$1,000,000. DO NOT USE IF DISABILITY INCOME OR DISABILITY OVERHEAD EXPENSE IS OVER \$8,000 PER MONTH. PREMIUM SHOULD NOT BE ACCEPTED IF THE PROPOSED INSURED IS AGE 75 OR OLDER, OR HAS BEEN TREATED FOR HEART DISEASE, DIABETES, STROKE, OR CANCER, WITHIN THE PAST 12 MONTHS, OR HAS BEEN ADMITTED TO A MEDICAL FACILITY WITHIN THE PAST 90 DAYS.

Terms and Conditions

All of the terms and conditions of this receipt must be fulfilled for insurance to be in effect on the "coverage date" or no insurance will be in effect under this receipt. The "coverage date" is the date of this application or Part II or medical examination or other test required by published rules of the companies listed above ("the Companies") used when considering the benefits applied for, whichever date is latest.

1. Premium Payment

For Adjustable Life insurance, the premium payment taken with this application must be equal to or greater than the full initial premium. For any other life insurance, or Disability Income insurance, the premium taken with this application must be equal to the full first premium for the mode of premium and benefits applied for.

2. Insurability

As of the "coverage date," the Companies' Underwriting Officer must find each person proposed for insurance to be an acceptable risk at standard premium rates for the benefits applied for without an exclusion or restrictive endorsement.

3. Conditional Insurance

If all of the conditions of this receipt are met, insurance under this receipt will be provided from the "coverage date" to the date the policy is delivered, subject to maximum amount limitations set out below.

4. a) Maximum Amount (applicable to life insurance only)

Any liability of the Companies under this and any other receipts may not exceed the lesser of: (a) the amount applied for in this application, or in the case of Adjustable Life insurance-the initial specified amount applied for; or (b) \$1,000,000 of insurance and \$100,000 of accidental death benefits.

b) Maximum Amount (applicable to Disability Income or Disability Overhead Expense only)

Any liability of the Companies under this and any other receipts may not exceed the lesser of: (a) the amount applied for in this application; or (b) \$8,000 per month of Disability Income or Disability Overhead Expense.

5. Termination of Conditional Insurance

If insurance is provided under this receipt, it will terminate when the policy(ies) is/are delivered. If the application is declined, the premium paid will be refunded and there will have been no coverage provided under this receipt.

6. Suicide

If any person proposed for insurance commits suicide, the Companies' liability under this receipt will be limited to a refund of the premium payment acknowledged above.

NOTICE TO APPLICANT - PLEASE READ THIS RECEIPT CAREFULLY.

No insurance is provided under this conditional receipt unless all terms and conditions of this receipt are met. This receipt is void if the payment is made by a check or draft that is not honored when presented for payment. Also void are any modifications made to the conditions of this receipt. All premium checks must be made payable to the appropriate Company. Do not make checks payable to the insurance producer or leave checks blank.

RECEIVED from _____

this _____ day of _____,

in the year of _____, by personal or business check,

the sum of \$ _____

in connection with this application for insurance, which application bears the same date as this receipt.

X _____
(Signature of Insurance Producer)

CHECK ALL COMPANIES THAT APPLY:

- 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

The undersigned hereby requests and directs The UNIFI company checked above to change policy number: _____
on the life of: _____

1. LIFE INSURANCE:

- a) Change Benefit Amount: Increase Amount Decrease Amount
To: \$ _____ (Base) To: \$ _____ * (Rider) To: \$ _____ * (Rider)
*Unless provided otherwise in the policy, an increase/decrease in the base will result in a proportionate increase/decrease in the Disability Benefit Amount, if any. No increase will be made to the Accidental Death Benefit unless specifically indicated above. However, if the base is decreased, the Accidental Death Benefit will decrease for a like amount.
- b) ADD CANCEL INCREASE to: \$ _____
 Scheduled Increase Option Accidental Death: _____
 Other Insured: Tobacco Non-Tobacco Guaranteed Insurability: _____
 Children's Insurance _____
 Cost of Living Rider _____
- c) Change Death Benefit Option to: OPTION A OPTION B OPTION D (VUL only)
(Evidence of insurability required to change to Option B or Option D)
- d) Change Planned Periodic Premium to: \$ _____ per Premium Interval.
(I understand any increase is subject to the expense charges shown in the Policy Schedule.)
- e) Election of Nonforfeiture Option (Applies to Whole Life only). Endorse as: Reduced Paid-Up Extended Term
- f) Change to Fully Paid-Up Policy.

2. DISABILITY INCOME:

- a) Change Occupation Class to: _____
- b) Change Waiting Period to: _____ days. Change Benefit Period (BP) to: _____
- c) ADD CANCEL INCREASE DECREASE TO: \$ _____ Catastrophic Amount: \$ _____
 Partial Disability Social Insurance (SIS) Future Increase Option Catastrophic Wait: _____
 Residual Disability Cost of Living Adjustment Automatic Increase (AIR) Catastrophic BP: _____
 Residual Disability (24 mo) Monthly Benefit AIR Renewal Other: _____
- d) Reconsider Rating and/or Exclusion Rider.

3. GENERAL:

- a) Change Premium Mode to: Annual Semiannual Quarterly
 Electronic Fund Transfer (Complete EFT form.) List Bill
- b) Change Tobacco Status to Non-Tobacco.
- c) Additional Details: _____

For any change, it is agreed that: (a) evidence of insurability will be furnished if required; and (b) any net value of a policy being changed to a new policy will be applied towards the new policy.

I hereby declare that: (a) no bankruptcy proceedings are now pending against the owner; and (b) no assignment of the policy numbered above has been made except to (if no exception, so state): _____

IMPORTANT: Please note, if the policyowner is a resident of a community property state (AZ, CA, ID, LA, NV, NM, TX, WA, and WI), the policyowner's spouse is required by that state to sign this form as "Other Required Signature". The form will be returned if incomplete. If the policyowner has never been married, then please state "Not Married" on the "Other Required Signature" line. If the policyowner is divorced or the spouse is deceased, we will need verification of this for our records for future requests, i.e., certified copy of death certificate, certified copy of divorce decree.

Dated at: _____ City _____ State _____ Month: _____ Day: _____ Year: _____

Insured Signature: _____ Owner Signature: _____

Other Required Signature: _____ Creditor Assignee: _____
If signing for a corporation, show corporate title.

Name of Corporation: _____

Officer: _____ Title: _____
Acknowledged: THE UNIFI COMPANIES

By: _____ Date: _____
(From Agency No.: _____) NOTE: Mail completed matter to: Owner Agency No.: _____

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

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ME RESIDENTS

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NJ RESIDENTS

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OR RESIDENTS

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VA RESIDENTS

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

SERFF Tracking Number: UNNC-125710473 *State:* Arkansas
Filing Company: Acacia Life Insurance Company *State Tracking Number:* 39418
Company Tracking Number: UN 1767
TOI: L08 Life - Other *Sub-TOI:* L08.000 Life - Other
Product Name: UNIFI Supplemental Applications-ACLIC
Project Name/Number: UNIFI Supplemental Applications/UN 1767, et al

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number: UNNC-125710473 State: Arkansas
Filing Company: Acacia Life Insurance Company State Tracking Number: 39418
Company Tracking Number: UN 1767
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: UNIFI Supplemental Applications-ACLIC
Project Name/Number: UNIFI Supplemental Applications/UN 1767, et al

Supporting Document Schedules

Review Status:

Satisfied -Name: Certification/Notice

06/25/2008

Comments:

Attachments:

Reg 19 Cert.pdf

Reg 49 Cert.pdf

UNIV READABILITY CERT.pdf

Review Status:

Satisfied -Name: Exhibit A & B

06/25/2008

Comments:

Attachments:

EXHIBIT A.pdf

EXHIBIT B - App descripts.pdf

Reg 19 CERTIFICATION
Arkansas

I, Elizabeth F. Martini, an office for Acacia Life Insurance Company and The Union Central Life Insurance Company, hereby certify that we have reviewed Rule and Regulation 19 and that we meet the provisions of said Rule and Regulation, as well as all applicable requirements of your Department regarding Unfair Sex Discrimination in the Sale of Insurance.



Elizabeth F. Martini
Vice President & Managing Attorney

June 25, 2008
Date

I, Robert F. Lange, an office for Ameritas Life Insurance Corp. hereby certify that we have reviewed Rule and Regulation 19 and that we meet the provisions of said Rule and Regulation, as well as all applicable requirements of your Department regarding Unfair Sex Discrimination in the Sale of Insurance.



Robert G. Lange
Vice President, General Counsel and Assistant Secretary

June 25, 2008
Date

Reg 49 CERTIFICATION
Arkansas

I, Elizabeth F. Martini, an office for Acacia Life Insurance Company and The Union Central Life Insurance Company hereby certify that we have reviewed Arkansas Rule and Regulation 49 and that we are in compliance regarding Life and Health Insurance Guaranty Association Notices.

I also certify that we have reviewed ACA 23-79-138 regarding the use of Complaint Notices and assure that we are in compliance.



Elizabeth F. Martini
Vice President & Managing Attorney

June 25, 2008
Date

I, Robert F. Lange, an office for Ameritas Life Insurance Corp. hereby certify that I have reviewed Arkansas Rule and Regulation 49 and that we are in compliance regarding Life and Health Insurance Guaranty Association Notices.

I also certify that we have reviewed ACA 23-79-138 regarding the use of Complaint Notices and assure that we are in compliance



Robert G. Lange
Vice President, General Counsel and Assistant Secretary

June 25, 2008
Date

Reg. Section 6 DI: Method of Disclosure of Required Information

All information required to be disclosed by this rule shall be set out conspicuously and in close conjunction with the statements to which such information relates or under appropriate captions of such prominence that it shall not be minimized, rendered obscure or presented in an ambiguous fashion or intermingled with the context of the advertisements so as to be confusing or misleading.

Reg. Section 6 Life: Valuation

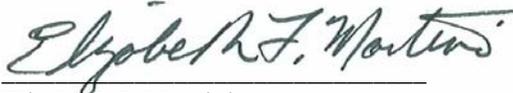
The minimum valuation standard for universal life insurance policies shall be the Commissioners Reserve Valuation Method

READABILITY CERTIFICATION

I, Elizabeth F. Martini, an officer of Acacia Life Insurance Company and The Union Central Life Insurance Company, hereby certify that the following form(s) has (have) the following readability score(s) as calculated by the Flesch Reading Ease Test and that this (these) form(s) meet(s) the reading ease requirements of the laws and regulations of your state.

<u>Form</u>	<u>Form Title</u>	<u>Readability Score</u>
--------------------	--------------------------	---------------------------------

See attached Exhibit A



Elizabeth F. Martini
Vice President & Managing Attorney

6/25/08

I, Robert G. Lange, an officer of Ameritas Life Insurance Corp., hereby certify that the following form(s) has (have) the following readability score(s) as calculated by the Flesch Reading Ease Test and that this (these) form(s) meet(s) the reading ease requirements of the laws and regulations of your state.

<u>Form</u>	<u>Form Title</u>	<u>Readability Score</u>
--------------------	--------------------------	---------------------------------

See attached Exhibit A



Robert G. Lange
Vice President, General Counsel and Assistant Secretary

6/25/08

EXHIBIT A
UNIFI Supplemental Applications

ACACIA FORMS:

Form #	Description	Form # Replacing	Previous Approval Date	Flesch Scores *
UN 1767	Application for Life Reinstatement	F-152 Rev. 10-87	02/29/88	79
UN 1799	Application for Change of Coverage	L-5A Ed. 3-07	04/11/07 - 12/07/07	56
UN 2597	Part II - Non Medical	n/a	n/a	84
UN 2598	Part II - Medical	n/a	n/a	81
UN 2611	Application to Exercise Option to Purchase Additional Insurance	719A Rev. 10-05	10/17/05 - 08/07/06	51
UN 2852 B	Application for Policy Change	719A Rev. 10-05	10/17/05 - 08/07/06	51

*Flesch score excludes medical terminology.

AMERITAS FORMS:

Form #	Description	Form # Replacing	Previous Approval Date	Flesch Score *
UN 1767	Application for Life Reinstatement	719B Rev. 10-98	11/19/98 - 08/30/02	79
UN 1799	Application for Change of Coverage	719B Rev. 10-98 L-5 Rev. 3-86 L-6 Rev. 10-98	11/19/98 - 08/30/02 05/01/86 - 08/30/02 11/19/98 - 08/30/02	56
UN 2597	Part II - Non Medical	L-1 Rev. 01-05	02/08/04 - 01/23/06	84
UN 2598	Part II - Medical	L-1 Rev. 01-05	02/08/04 - 01/23/06	81
UN 2611	Application to Exercise Option to Purchase Additional Insurance	719A Rev. 10-05	10/17/05 - 08/07/06	51
UN 2852 B	Application for Policy Change	719A Rev. 10-05	10/17/05 - 08/07/06	51

*Flesch score excludes medical terminology.

UNION CENTRAL FORMS:

Form #	Description	Form # Replacing	Previous Approval Date	Flesch Scores **
UN 1767	Application for Life Reinstatement	UC 1767-1	12/01/98 - 07/30/01	54
UN 1799	Application for Change of Coverage	UC 1799	12/01/98 - 07/27/05*	60
UN 2597	Part II - Non Medical	UC 2597 B	02/16/90 - 05/30/91	53
UN 2598	Part II - Medical	UC 2598 B	02/16/90 - 05/30/91	55
UN 2611	Application to Exercise Option to Purchase Additional Insurance	UC 2611-1	12/01/98 - 07/27/05	55
UN 2852 B	Application for Policy Change	UC 2852 B 3	03/22/06 - 11/05/07	53

*Flesch score excludes medical terminology.

Exhibit B
Explanation of Amendment of Applications

- UN 1767** This form is the application for policy reinstatement and is used when a policy has lapsed.
- UN 1799** This form asks for medical information in conjunction with policy changes.
- UN 2597** This form asks the client medical history. It will always be used in conjunction with the base application.
- UN 2598** This form asks for medical history plus height, weight and blood pressure readings from a paramed. It can also be used as a full medical examination by a doctor that includes additional medical history. It will always be used in conjunction with the base application.
- UN 2611** This form is used by clients who have the Future Purchase Guarantee Rider on their policies and wish to exercise their right to purchase additional insurance. The form lets us know the amount they are exercising for the purchase and the plan of insurance they are choosing. It is used in lieu of completing a full UN2550 as the client is opting to purchase coverage that has been guaranteed and no underwriting is required.
- UN 2852 B** This form is used to request a policy change.