REQUEST TO INSPECT OR COPY

I, _____, am an insured member of Ameritas Life Insurance
(print name)

Corp. /Ameritas Life Insurance Corp. of New York (collectively "Ameritas") dental

and/or vision plan through _____
(please print name of employer/group)

I hereby request that Ameritas provides me with a copy of records containing my Protected Health Information as follows:

Please state the type of records desired (ie. claims information, enrollment information, payment information, correspondence with my provider regarding me, etc.):

_____ for the dates between and _____.

Please send the paper records to me as follows:

☐ Mail to: _____
_____

☐ Fax to: _____

☐ Other: _____

PLEASE NOTE: It is our Policy not to send unsecured protected health information to anyone over an open network. Therefore, PHI CANNOT BE E-MAILED TO YOU WITHOUT FIRST BEING ENCRYPTED.

Signature _____ Date _____

Please return this completed form to:

Ameritas Group Privacy
PO BOX 82520
Lincoln NE 68521
402-309-2580 (Fax)

Ameritas will send a written confirmation when this request is received.

Form PO-0005
Rev. 9/27/2011