REQUEST TO RESTRICT/TERMINATE
RESTRICTIONS ON CERTAIN DISCLOSURES

I, _____, am an insured member of an Ameritas Life Insurance
(print name)
Corp./Ameritas Life Insurance Corp. of New York (collectively "Ameritas") dental

and/or vision plan through _____. I hereby request that Ameritas
(please print name of employer/group)
NOT disclose the following PHI about me to:

_____:
(Name the person(s) or organization(s) that you do not your PHI disclosed to)

Describe the PHI you are requesting to have restricted:

_____

_____ _____
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.

NOTICE OF TERMINATION OF RESTRICTION:

By Individual:

I hereby request that AMERITAS terminate this restriction as of today's date.

_____ _____
Signature **Date**

By Ameritas:_____

Ameritas hereby notifies you that as of the date indicated below, this previously agreed to restriction is terminated:

Date of Termination: _____

Signature of Authorized Party:_____

Form PO-0006
Rev. 9/27/2011