1112

✓ CHECK ONE
□ **AMERITAS LIFE INSURANCE CORP.**
□ **ACACIA LIFE INSURANCE COMPANY**
(Hereinafter referred to as the Company)
SERVICE CENTER / P.O. Box 81889 Lincoln, NE 68501-1889 / 800-745-1112 / Fax 402-467-7335

AUTHORIZATION AGREEMENT TO RELEASE POLICY INFORMATION TO DESIGNATED INDIVIDUAL

Policyowner(s): _____ **Policy Number(s):** _____

Insured(s): _____

As policyowner, I hereby authorize and direct the Company to send one copy of policy information relating to the above policy to the following designated individual:

_____
(Name)

_____
(Address)

_____
(SSN OR TIN)

I understand that, as policyowner, I will continue to receive the originals of such policy information. The designated individual is not authorized to withdraw monies from or make any other policy changes or to act in any way on my behalf in regard to the above Policy(ies). I also understand that monitoring policy activity is my responsibility.

Termination of Authorization: This Authorization will continue to be in force until the earlier of (1) written notice is received from the owner revoking this authorization or (2) the Company terminates this agreement by written notice to the owner.

Indemnification: I agree to indemnity and hold harmless the Company, their affiliates, and their directors, officers, employees, and agents from and against all claims, actions, costs and liabilities, including attorney's fees, arising out of or relating to this Authorization Agreement.

_____ _____
(Date) *(Owner)*

_____ _____
(Date) *(Witness)*

Recorded and Filed by the Company on _____, _____

Recorded by the Home Office

By: