

REQUEST FOR ACCOUNTING OF DISCLOSURES OF PHI

I, _____, an insured member of an Ameritas Life Insurance
(print name)
Corp./First Ameritas Life Insurance Corp. of New York (collectively "Ameritas")
dental and/or vision plan through _____, hereby request an
(Employer or Group Name)
accounting of the disclosures of my PHI that have been made by Ameritas as
described by the Ameritas Acacia Companies Notice of Protected Health Information
Privacy Practices ("Notice") for the period of time beginning on
_____, 20__ and ending on _____, 20__.

I understand that certain disclosures are not accountable under applicable law, such
as disclosures that relate to treatment, payment or healthcare operations, and that
Ameritas will account for the disclosures described in the Notice as required by law.

Signature

Date

Address:

Please complete the above statement and return the completed information 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.