

REQUEST FOR ALTERNATIVE MEANS OF COMMUNICATION

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

Life Insurance Corp./First 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 no longer contact me at my home address, but

instead uses the following alternative method to contact and/or correspond with me:

(Check and Complete all that Apply)

Alternative Address: _____
C/o: _____

Alternative Phone Number: _____

Alternative Fax Number: _____

Alternative Email Address: _____

Other: _____

Signature

Date

Please return the 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.