

**REQUEST FOR AMENDMENT OF
PROTECTED HEALTH INFORMATION**

I, _____, am 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 _____. I believe that certain
(please print name of employer/group)
protected health information that Ameritas maintains about me is incorrect. Therefore, I

hereby request that Ameritas amend the following information that it maintains on me:

Describe the PHI you are requesting to have amended and attach any evidence to support your request:

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.