

## REQUEST TO INSPECT OR COPY

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 hereby request  
that \_\_\_\_\_  
(please print name of employer/group)

Ameritas provides me with a copy of records containing my Protected Health  
Information as follows:

Please state the type of records desired (ie. claims information, enrollment information, payment  
information, correspondence with my provider regarding me, etc.):

\_\_\_\_\_ for the dates between  
\_\_\_\_\_ and \_\_\_\_\_. Please send the  
paper records to me as follows:

- Mail to:** \_\_\_\_\_
- Fax to:** \_\_\_\_\_
- Other:** \_\_\_\_\_

**PLEASE NOTE: It is the Policy of the Ameritas Acacia Companies not to send  
unsecured protected health information to anyone over an open network. Therefore,  
PHI CANNOT BE E-MAILED TO YOU WITHOUT FIRST BEING ENCRYPTED.**

\_\_\_\_\_  
**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.**