

**REQUEST TO RESTRICT/TERMINATE  
RESTRICTIONS ON CERTAIN DISCLOSURES**

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 Ameritas  
(please print name of employer/group)  
NOT disclose the following PHI about me to:

\_\_\_\_\_  
(Name the person(s) or organization(s) that you do not your PHI disclosed to)

Describe the PHI you are requesting to have restricted:

\_\_\_\_\_

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

**NOTICE OF TERMINATION OF RESTRICTION:**

By Individual:

I hereby request that AMERITAS terminate this restriction as of today's date.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

By Ameritas: \_\_\_\_\_

Ameritas hereby notifies you that as of the date indicated below, this previously agreed to  
restriction is terminated:

Date of Termination: \_\_\_\_\_

Signature of Authorized Party: \_\_\_\_\_