## 5. Medical Information and Authorization

Please complete this section if all or any portion of the insurance coverage was issued within two years of the insured's death.

**Please list the insured's family doctor as well as the names, addresses and telephone numbers of any other physicians, clinics and hospitals that may have treated the insured during the past five years.**

| | | ( ) |
|---|---|---|
| **Primary Care Physician** | | *Telephone Number* |
| *Street Address* | *City, State, Zip Code* | *Condition* |

| | | ( ) |
|---|---|---|
| Physician or Hospital Name | | *Telephone Number* |
| *Street Address* | *City, State, Zip Code* | *Condition* |

| | | ( ) |
|---|---|---|
| Physician or Hospital Name | | *Telephone Number* |
| *Street Address* | *City, State, Zip Code* | *Condition* |

**Medical Authorization:**

I give my permission to release information concerning ________________________________________ who died on ______________ to New York Life including its agents, attorneys, reinsurers and insurance support groups acting on their behalf. Information released may include records of medical advice, medical care, medical treatment of AIDS or AIDS-related diseases, mental illness, drug or alcohol abuse, other insurance coverage, financial and employment history. This information may be released by medical professionals or facilities, pharmacies, government offices, employers, insurance companies, insurance support groups, group policy holders or benefit plan administrators. When requesting information from any of the sources named above, a copy of this form is as good as the original. I am aware that any information obtained will be used to judge my claim. I understand that my claim will not be processed unless this authorization is completed and signed. Either I, or a person I choose, am entitled to receive a copy of this signed authorization. This authorization is valid from the date signed until the claim is resolved, except in those states, which allow for only a one-year limit.

I have the right to revoke this authorization at any time by notifying New York Life in writing at the address on this authorization. My revocation will not be effective to the extent New York Life or any other person already has disclosed or collected information or taken other action in reliance on this authorization. My revocation will also not be effective to the extent state law gives New York Life the right to contest a claim under the policy or the policy itself.

The information New York Life obtains based on this authorization may be subject to further disclosure. For example, New York Life may be required to provide it to an insurance regulatory or other government agency. In this case, the information may no longer be protected by the rules governing this authorization.

| **Signature** | **Relationship to Insured** | **Date** |
|---|---|---|
| | | |

**Return this Claim Form and a Certified Copy of the death certificate to:**
**New York Life Insurance Company/AARP Operations**
**P.O. Box 30713**
**Tampa, FL 33630-3713**