TRUSTMARK LIFE INSURANCE COMPANY OF NEW YORK
126 South Swan Street, Suite 203
Albany, NY 12210

ACKNOWLEDGEMENT AND AUTHORIZATION TO OBTAIN INFORMATION

I authorize the entities listed in this authorization to give Trustmark Life Insurance Company of New York, and through it, to its reinsurers any data or records including pharmaceutical records that are individually identifiable in the entities' possession about the mental or physical health of me or any proposed insured in this authorization. This authorization is for: any medical practitioner; hospital; clinic or other medically related facility; pharmacy; Pharmacy Benefit Manager, insurance company; the MIB, Inc., formerly known as the Medical Information Bureau; or other organization, institution, or person which may have information about me pertinent to determine my eligibility for insurance as allowed or required by law. I also authorize Trustmark Life Insurance Company of New York, or its' reinsurers, to make a brief report of my protected health information to MIB. Information for consumers about MIB may be found at www.mib.com. This authorization is valid for two years from the date of this authorization. A photographic or facsimile copy of this authorization will be as valid as the original. I understand that I can revoke this authorization at any time by giving written notice to Trustmark Life Insurance Company of New York. I understand that I may refuse to sign this authorization and still be assured treatment. Information disclosed under this authorization may be re-disclosed by recipient as permitted by law and may no longer be protected by HIPAA. (The person who signs this authorization may have a copy of it upon request.)

I acknowledge that I have received and read a copy of the company's Investigative Consumer Report Notification which includes: 1) Fair Credit Reporting Act; 2) MIB, Inc.; and 3) the Notice of Information Practices which includes the investigative consumer reports notification. I further acknowledge that an investigative consumer report may be made and that I may ask to be interviewed for this report. I hereby authorize such a report.

I acknowledge the application for life insurance on my life in the amount of $ _____

Name of Employee: _____

Name of Employer: _____

Employee Social Security Number: _____

Name of Insured (Spouse/Domestic Partner/Child (age 18 and over):

_____

Signature of Proposed Insured or Authorized Representative or Legal Guardian:

_____ _____
Signature of Spouse/Domestic Partner if to be Insured **Soc. Sec. No**

_____ _____
Signature of Co-owner or Child age 18 and over **Soc. Sec. No**

_____ _____
Signature of Employee **Soc. Sec. No**

_____ _____
Date Signed **Application Number**

Return this signed form to: Trustmark Life Insurance Company of New York, PO Box 7962, Lake Forest, IL 60045-7962

Due Date: _____

P321-7 NY R1211