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Name of proposed insured/patient (please print)

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Date of birth

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years ("My Providers") to disclose my entire medical record and any other personal health information concerning me to Standard Security Life Insurance Company of New York and its affiliated insurance companies, its agents, employees, and representatives (collectively referred to as "The Companies"). This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco. This authorization also allows my current or former employer to release information needed to process and evaluate my claim. If applicable this also includes any part of my no fault insurance file if my disability is the result of a motor vehicle accident.

By my signature below, I acknowledge that any agreements I have made to restrict my personal health information do not apply to this authorization and I instruct My Providers to release and disclose my entire medical record without restriction.

This personal health information is to be disclosed under this Authorization so that The Companies may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with The Companies.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to Standard Security Life Insurance Company of New York and its affiliated insurance companies at P.O. Box 25339 Farmington, New York 14425-0339. I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that The Companies have a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and is no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that My Providers may not refuse to provide treatment if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, The Companies may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I acknowledge that I have received a copy of this authorization.

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Signature of Proposed Insured/Patient or Personal Representative

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Date

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Print name of signature above

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Description of Personal Representative's Authority or Relationship to Patient