

**Tax Certification**

Under penalties of perjury, I (as the owner named in Section A or B) certify that: (1) the Social Security or Employer ID Number shown in this application is my correct taxpayer identification number, or I am awaiting a number to be issued to me (noted as "applied for" in Section A or B) AND (2) I am not subject to backup withholding because: (a) I am exempt from backup withholding; or (b) I have not been notified by the IRS that I am subject to backup withholding as a result of a failure to report all interest or dividends; or (c) the IRS has notified me that I am no longer subject to backup withholding (Cross out item 2 if the IRS has notified you that you are subject to backup withholding.) and (3) I am a U.S. person (including a U.S. resident alien).

**ACKNOWLEDGEMENT**

I, the Proposed Insured, have been given a copy of "Information Practices Related to Underwriting Your Application" which tells how New York Life Insurance Company, New York Life Insurance and Annuity Corporation and NYLIFE Insurance Company of Arizona obtain and use data about me. It includes the notice required by the State and Federal Fair Credit Reporting Acts and a description of MIB, Inc. (Medical Information Bureau). I know that my application cannot be processed if I do not sign the authorization below.

**AUTHORIZATION**

In this Authorization, "I" means the Proposed Insured, "the Insurer" means New York Life Insurance Company, New York Life Insurance and Annuity Corporation, and NYLIFE Insurance Company of Arizona and their respective agents, employees, and representatives. In order to see if (and on what basis) I qualify for the insurance applied for or any other insurance offered by any of the insurers identified above, I authorize the following:

**MEDICAL INFORMATION** Physicians or practitioners; hospitals; medical or medically related facilities; laboratories; insurance companies; or MIB may give to the Insurer (or any consumer reporting agency acting in its behalf) and to any of its reinsurers, at my request, copies of the record or other data that they may have about my physical and mental health. This includes all protected health information and any health information I have previously requested be withheld from further disclosure, and including my history, their findings, diagnoses and treatment. Mental health professionals may provide their records of my diagnosis, functional status, treatment plan, symptoms, prognosis, progress to date, medication prescription and monitoring, and clinical test results.

**OTHER UNDERWRITING INFORMATION** MIB and other insurance companies may give to the Insurer and to any of its reinsurers data about: my driving record; any criminal activity or association; hazardous sport or aviation activity; use of alcohol or drugs; any claim of eligibility for disability income benefits; and other applications for insurance.

**EXAMINATIONS AND TESTS** The Insurer may obtain physical examinations or medical tests deemed necessary to underwrite my application. These tests (where permitted by law) may include, but are not limited to, electrocardiograms, chest x-rays and tests of blood and urine to determine, among other things, exposure to causative agents of disease (for example, exposure to the AIDS virus) and the presence of drugs. However, a separate notification/authorization form will be provided with respect to testing for the AIDS virus.

**INVESTIGATIVE CONSUMER REPORT** The Insurer may obtain an investigative consumer report and may give the consumer reporting agency information concerning the amount and type of my coverage and my use, if any, of tobacco. The report may add to or confirm the types of data mentioned above. It may also contain data about: my identity; age; residence; marital status; past and present jobs (including work duties); economic conditions; driving record; personal and business reputation in the community; and mode of living; but will not include any information relating directly or indirectly to sexual orientation.

**IDENTIFICATION** To obtain the data described above, the Insurer may give my name, address, and date and place of birth to the above persons or organization.

**RELEASE OF INFORMATION TO OTHERS** When necessary, the Insurer may give data about me that affects my insurability to: its subsidiaries; its affiliates; its parent company; its agents and their staffs; its reinsurers; and the Insurer and its reinsurers may give such data to MIB. However, this will not be done in connection with information relating to the AIDS virus.

I also authorize the release of these same types of data about any of my children who are to be insured. This Authorization may be used for a period of 24 months from the date signed below unless sooner revoked. I may revoke this Authorization at anytime by notifying the Insurer in writing. This revocation will not be effective to the extent the Insurer or any other person already has disclosed or collected information or taken other action in reliance on it. The information the Insurer obtains through this Authorization may become subject to further disclosure. For example, the Insurer 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. A photocopy of this Authorization and request form shall be as valid as the original. I know that I may request a copy of this Authorization. (Please provide a copy to me. \_\_\_\_\_ initial if requested).

**The Internal Revenue Service Does Not Require Your Consent To Any Provision Of This Document Other Than The Certifications Required To Avoid Backup Withholding. Signatures**

By signing below, I/We understand that I/We acknowledge and agree to all of the statements and representations made in this application, including sections entitled Statement of Agreement, Illustration (if applicable), Check-O-Matic (if applicable), Tax Certification, Acknowledgement and Authorization. I/We accept and adopt as true all statements made by the Proposed Insured(s) in this application.

X \_\_\_\_\_ Signed at \_\_\_\_\_ On \_\_\_\_\_  
Signature of the Primary Insured (Parent or Guardian if under 14 years 6 months) (City, State) (MM/DD/YYYY)

X \_\_\_\_\_ Title if signed on behalf of Corporation, Trust, etc.  
Signature of the Owner if Other than the Primary Insured

X \_\_\_\_\_ X \_\_\_\_\_  
Signature of Applicant if Other than Primary Insured or Owner Signature of Other Insured

X \_\_\_\_\_ X \_\_\_\_\_  
Signature of Other Insured Signature of Other Insured

X \_\_\_\_\_  
Other Required Signature

I Certify I have truly and accurately recorded all answers given to me.

X \_\_\_\_\_ X \_\_\_\_\_  
Signature of Agent/Witness Countersigned by Licensed Resident Agent (if required)

X \_\_\_\_\_  
Signature of Agent/Witness Countersigned Code #