TIAA CREF
Financial Services

TIAA-CREF LIFE INSURANCE COMPANY

Authorization for Release of Health-Related Information

This authorization complies with the HIPAA Privacy Rule.

Name of Proposed Insured (please print): _____

I authorize any health plan, physician, healthcare professional, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, medical facility, or other healthcare provider that has provided payment, treatment, or services to me or on my behalf ("My Providers") to disclose my entire medical record and any other protected health information concerning me to TIAA-CREF Life Insurance Company ("Company"), its agents, employees, representatives and reinsurers. This includes information on the diagnosis and 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, but excludes psychotherapy notes.

I also authorize any insurance company, MIB, Inc. ("MIB"), or other organization, institution, or person ("Other Persons") that has any records or knowledge of me or my health, to give to the Company and its agents, employees, representatives and reinsurers any such information. 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, but excludes psychotherapy notes.

By my signature below, I terminate any agreements I have made with My Providers or with Other Persons to restrict my protected health information and I instruct My Providers and Other Persons to release and disclose my entire medical record and other records or knowledge of me or my health without restriction.

I further authorize TIAA-CREF Life Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB, Inc.

This protected health information is to be disclosed under this Authorization so that the Company may: (1) underwrite my application for coverage, make risk rating determinations and make policy issuance determinations; (2) obtain reinsurance; (3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; and (4) conduct other legally permissible activities that relate to any coverage I have applied for with TIAA-CREF Life Insurance Company.

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 **TIAA-CREF Life, Attention: Privacy Official, 8500 Andrew Carnegie Boulevard, Charlotte, NC 28262-8500.**

I understand that a revocation is not effective if My Providers and Other Persons have relied on this Authorization or to the extent that TIAA-CREF Life Insurance Company has 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 no longer covered by certain federal rules governing privacy and confidentiality of health information.

I also understand that if I refuse to sign this Authorization, the Company may not be able to process my application. I acknowledge that I have a right to receive a copy of this Authorization.

_____ _____

Signature of Proposed Insured or Personal Representative Date

_____

Description of Personal Representative's authority or relationship to Proposed Insured