NASSAU

Nassau Life and Annuity Company (the Company)
Nassau Life Insurance Company (the Company)
PHL Variable Insurance Company (the Company)
Nassau Life and Annuity Insurance Company (the Company)

Supplemental Questionnaire *and* Authorization

Return form to: Individual Benefits, PO Box 22012, Albany NY 12201-2012

INSURED	POLICY NUMBER	CLAIM NUMBER

DIAGNOSIS: (If an accident, please provide us with any details of the circumstances or provide copies of accident reports, police reports, news clippings, etc.)

When did insured first complain of or give other indication of the illness? _____

When did insured first consult a physician for the illness? _____

Names and addresses of all physicians or practitioners who attended the insured during the past five (5) years.

Name and Address	Dates	Disease or Condition

Names and addresses of all hospitals or institutions where the insured was treated during the past five (5) years.

Name and Address	Disease or Condition	Date Admitted

PRINT FULL NAME AND ADDRESS OF INSURED'S EMPLOYER

INSURED'S OCCUPATION	DATE LAST WORKED

NAME AND ADDRESS OF INSURED'S EMPLOYER'S HEALTH INSURANCE CARRIER

Were any medications prescribed by a physician? ☐ YES ☐ NO If **yes**, please indicate the name and address of the drug store where the prescription was filled, date prescribed and name of prescribing physician.

State law, in some states, requires the following: A person commits a fraudulent insurance act, which is a crime, if he or she knowingly and with intent to defraud any insurance company or other person, either; (1) files a statement of claim that contains any materially false information; or (2) conceals for the purpose of misleading, information about any fact that is material to a claim.

For your protection, California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Please date and sign the authorization on the reverse side.

Authorization to Obtain and Redisclose Information

The completion of this authorization is required for the purpose of obtaining information to adjudicate your claim for benefits.

Mandatory Authorization

To: Any physician, medical practitioner, hospital, clinic, pharmacy, health care or other medical related facility or provider of medical or dental services or supplies, any insurance or reinsurance company, any group policy holder, employer, benefits plan administrator or business associate, any consumer reporting agency or financial institutions, any Federal, State or local governmental agencies, including but not limited to the Social Security Administration and the Veteran's Administration.

I authorize the above to release all information about mental and physical history, consultations, prescriptions, care and treatment, diagnosis and prognosis, (including drug/alcohol abuse information), HIV-related, AIDS or AIDS related Complex (ARC), to the extent permitted by law; and any employment, financial and wage information, Federal or State income filings or information with respect to other insurance coverage of the Insured for which a claim is being made, to release to the Company, its affiliates and its representatives or agency, attorney, consumer reporting agency, or independent administrator acting in it's behalf, any and all such information, data or records.

I understand that the information released under this authorization will be used for the purpose of evaluating a request for insurance coverage or evaluating and administering a claim for benefits and I authorize the Company to disclose the information for that purpose to any reinsurer, Medical Information Bureau, LLC (MIB, LLC), (HCI) and other insurance companies or self-insurers to whom claim for benefit's may be submitted. I also authorize the Company to redisclose the information to any person performing a business or legal function for it's benefit, to an attending physician for diagnostic or treatment purposes, to government authorities, State Insurance Department and Regulatory agencies when necessary to prevent or prosecute fraud or other illegal activities and to any person who has an authorization specifically permitting the disclosure.

I understand that information hereunder will not be redisclosed to any other person or institution except as listed above.

This authorization will be valid for the longer of: a claim for life, health, and disability insurance benefits; or two years from the date shown below, with respect to a claim for benefits.

I know that I have right to request and receive a copy of this authorization. A photocopy of this authorization shall be as valid as the original.

PROPOSED INSURED, INSURED OR CLAIMANT

DATE AUTHORIZATION SIGNED

SIGNATURE OF PROPOSED INSURED OR CLAIMANT,
BENEFICIARY OR AUTHORIZED REPRESENTATIVE
(parent or guardian, if minor)

POLICY NUMBER

If guardian or estate representative, please send a copy to the appointment papers.