MassMutual

Voluntary Authorization to Release Information

For use with Life, Disability Income (DI) & Long Term Care (LTC)

The purpose of this form is to authorize Massachusetts Mutual Life Insurance Company ("MassMutual") to ***release information, including non-public personal health and financial information, about the Proposed Insured*** *(also referred to as "I" or "me" or "my") to the Agent or Broker who submitted an application to MassMutual on my behalf and/or the General Agency with whom the Agent or Broker is contracted (collectively the "Agent/Broker/Agency") and to be used as described below.*

A Proposed Insured Information

1. Full legal name *(First, MI, Last, Suffix):* ____________________
2. Date of birth *(mm/dd/yyyy):* ____________________

B Disclosures

Authorization for Disclosures of Personal Health Information. I authorize MassMutual to disclose information as described below to the Agent/Broker/Agency for the following purposes: (1) to provide me with additional information regarding the underwriting decisions made in connection with the application for insurance submitted to MassMutual; and/or (2) to determine eligibility for and obtaining insurance products from other insurance companies.

For the purpose of determining that I am eligible for proposed insurance with another insurance company, I specifically authorize the Agent/Broker/Agency to release any and all information it receives about me pursuant to this authorization to other insurance companies and their respective reinsurers, underwriters or other persons or organizations performing business, professional or insurance functions for them.

Information to be used or disclosed. This authorization allows for the disclosure of my application for insurance submitted to MassMutual and all information obtained during the underwriting of that application, including, but not limited to: (1) attending physician statements, medical history and other information that relates to the diagnosis, treatment or prognosis of any physical or mental condition, whether in electronic or paper form; (2) information related to psychiatric or psychological conditions (excluding psychotherapy notes), prescription drugs and pharmaceutical records, medical claim reports, diagnostic testing, laboratory records, alcohol or drug use (excluding any data protected by Federal Regulation 42 CFR Part 2), communicable or infectious diseases or conditions such as Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS) and genetic information, including genetic tests, unless otherwise restricted by federal or state laws; and (3) medical or health information from the following persons or entities who have provided payment, treatment or services within the past 10 years: a physician, medical practitioner or health care professional or provider, hospital, clinic, laboratory, medical or medically related facility, pharmacy or pharmacy benefit manager and/or health plan, any insurance company, reinsurance company, any consumer reporting agency, the Department of Motor Vehicles or any other state or federal government agency and/or any other organization, institution or person having nonpublic personal information.

Redisclosure of information. I understand that any information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected under federal or state privacy laws.

Revocation of authorization. I understand that I may revoke this authorization at any time by sending a written request to: Massachusetts Mutual Life Insurance Company – Underwriting Department, 1295 State Street, Springfield, MA 01111-0001, Attention: Authorization Administrator. I also understand that any such revocation will not be effective to the extent that action has been taken by the Company in reliance on this authorization, or the extent that the Company has a legal right to contest a claim under the policy which I have applied for or to contest the policy itself.

Expiration of authorization. This authorization will be valid for 12 months from the date of my signature.

C Agreements & Signature

I understand that execution of this authorization is voluntary and that I can refuse to sign this authorization. I understand my refusal to sign this authorization will not prevent MassMutual from underwriting my application for insurance. I understand that I will receive a copy of this authorization and a copy of this authorization is valid as the original.

Signature

Signature of Proposed Insured/Personal Representative: ____________________

Printed name: ____________________ Date: __________

Relationship to Proposed Insured *(If Personal Representative):* ____________________

Massachusetts Mutual Life Insurance Company (MassMutual), 1295 State Street, Springfield, MA 01111-0001 and its subsidiaries: C.M. Life Insurance Company and MML Bay State Life Insurance Company, 100 Bright Meadow Boulevard, Enfield, Connecticut 06082-1981.

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For the purpose of determining that I am eligible for proposed insurance with another insurance company, I specifically authorize the Agent/Broker/Agency to release any and all information it receives about me pursuant to this authorization to other insurance companies and their respective reinsurers, underwriters or other persons or organizations performing business, professional or insurance functions for them.

Information to be used or disclosed. This authorization allows for the disclosure of my application for insurance submitted to MassMutual and all information obtained during the underwriting of that application, including, but not limited to: (1) attending physician statements, medical history and other information that relates to the diagnosis, treatment or prognosis of any physical or mental condition, whether in electronic or paper form; (2) information related to psychiatric or psychological conditions (excluding psychotherapy notes), prescription drugs and pharmaceutical records, medical claim reports, diagnostic testing, laboratory records, alcohol or drug use (excluding any data protected by Federal Regulation 42 CFR Part 2), communicable or infectious diseases or conditions such as Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS) and genetic information, including genetic tests, unless otherwise restricted by federal or state laws; and (3) medical or health information from the following persons or entities who have provided payment, treatment or services within the past 10 years: a physician, medical practitioner or health care professional or provider, hospital, clinic, laboratory, medical or medically related facility, pharmacy or pharmacy benefit manager and/or health plan, any insurance company, reinsurance company, any consumer reporting agency, the Department of Motor Vehicles or any other state or federal government agency and/or any other organization, institution or person having nonpublic personal information.

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