NASSAU RE

Nassau Life and Annuity Company (the Company)
Nassau Life Insurance Company (the Company)
PHL Variable Insurance Company (the Company)
One American Row, PO Box 5056, Hartford CT 06102-5056

HIPAA Authorization to Release Medical Information

THIS AUTHORIZATION COMPLIES WITH THE HIPAA PRIVACY RULE

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, 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 protected health information concerning me to the Company, its agents, employees, and representatives. 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 acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that the Company 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 including riders, features, changes and reinstatements; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with the Company.

This authorization shall remain in force for 30 months (24 months in Alaska, Colorado, Florida, Iowa, Kentucky, Montana, Nebraska, New Hampshire, New York, North Dakota, Oklahoma, Texas, West Virginia and Wyoming.) 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 the Company at One American Row, Hartford, CT 06103-2899, Attention: Chief Privacy Officer. 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 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 redisclosed and no longer covered by federal HIPAA rules governing privacy and confidentiality of health information. However, the Company maintains full compliance with other applicable federal and state privacy rules. A copy of the Company privacy policy is available upon request.

I understand that if I refuse to sign this authorization to release my complete medical record, the Company 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.

_____ _____

Name of Authorizing Party/Insured (please print) Date of Birth

_____ _____

Signature of Authorizing Party/Owner Date

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Description of Personal Representative's Authority or Relationship to Authorizing Party