B Agreements, Understandings and Signatures

If I do not sign this Authorization, the Company may (i) decline my application for insurance or not be able to offer me any coverage and/or (ii) decline to pay a claim for benefits under any insurance issued. Providers of health care services or medical treatment may not refuse to provide treatment or payment for health care services if I refuse to sign this Authorization.

- My Authorization may be revoked by sending a written request to:
  MassMutual, Attn: Authorization Administrator – Underwriting Department, 1295 State Street, Springfield, MA 01111-0001.
  I may not revoke any Authorization that was obtained as a condition of obtaining insurance, paying a claim, or that was relied or acted upon.
- This Authorization applies to my entire medical record. Any agreements I have made to restrict my medical or health information do not apply to this Authorization.
- My health information may be re-disclosed and no longer protected by HIPAA if the person receiving this information is not required to comply with HIPAA. HIPAA only regulates certain types of entities, such as insurers providing long-term care insurance and health care providers. However, the Company requires its employees, agents, representatives, insurance producers and service providers to protect the confidentiality of health information regardless of whether the employee, agent, representative, insurance producer or service provider is engaged in an insurance business subject to HIPAA. Information may only be re-disclosed in accordance with applicable laws or regulations.
- A copy or facsimile of this Authorization is valid as the original.
- This authorization is valid for twenty-four (24) months from the date I sign it.
- I have received a copy of this Authorization.

Some states' rules concerning Authorizations change the terms and provisions of this Authorization. By signing below, you acknowledge the conditions identified on page three are considered part of this Authorization and apply in the identified states.

Signature of Insured/Representative: _____

Printed name: KATERINE JIMENEZ Date: 2/23/2016

Date of birth *(mm/dd/yyyy)*: 12/20/70

Relationship to Insured *(If Representative)*: _____

B Agreements, Understandings & Signatures

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Signature of Insured/Representative: _____

Printed name: LORENE JIMENEZ Date: 12/23/16

Date of birth *(mm/dd/yyyy)*: 12/30/70

Relationship to Insured *(If Representative)*: _____

Massachusetts Mutual Life Insurance Company
1295 State Street, Springfield, MA 01111-0001

HIPAA Authorization

For use with Life, DI and Life with Long Term Care Riders

This Authorization complies with HIPAA Privacy Rule.
"HIPAA" is the Health Insurance Portability and Accountability Act of 1996, as amended.

A Authorizations

- I hereby authorize the use and disclosure of my medical records, 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. This includes, but is not limited to, information related to psychiatric or psychological conditions; prescription drugs and pharmaceutical records; diagnostic testing; laboratory records; alcohol or drug use; and communicable or infectious diseases or conditions such as Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS) and sexually transmitted diseases unless otherwise restricted by state law.
- This Authorization specifically excludes psychotherapy notes. Psychotherapy notes means notes recorded in any medium by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private, group, joint or family counseling session, and that are separated from the rest of any individual's medical record. Psychotherapy notes do not include medication prescription and monitoring, counseling session start and stop dates, modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the diagnosis, functional status, treatment plan, symptoms, prognosis and progress to date; therefore, such medical records are covered by this Authorization.
- I hereby authorize the following persons or entities who have provided payment, treatment or services to me or on my behalf within the past ten (10) years to disclose all medical or health information about me: a physician; medical practitioner or health care professional or provider; hospital; clinic; laboratory; medical or medically-related facility; pharmacy or pharmacy benefit manager; health plan. I further authorize the following persons or entities to disclose all medical or health information about me: any insurance company, including the Company ("Company" as referred to herein, is Massachusetts Mutual Life Insurance Company, and/or MML Bay State Life Insurance Company and/or C.M. Life Insurance Company), or reinsurance company; any consumer reporting agency such as the MIB, Inc. ("MIB"); the Department of Motor Vehicles or any other state or federal government agency; and/or any other organization, institution or person having personal health information about me.
- I hereby authorize the disclosure of my medical or health information to the Company, its service providers, its reinsurers and its agents, representatives and insurance producers (including the agents, representatives and employees of such persons or entities). I hereby authorize the disclosure of my medical or health information to any consumer reporting agency, including the MIB.
- I hereby authorize the use and disclosure of my medical or health information for purposes of and in connection with underwriting my application for insurance with the Company, determining the premium for the insurance, obtaining reinsurance, servicing my insurance and administering coverage, evaluating any claim for insurance benefits and conducting other legally permissible activities that relate to any coverage I have applied for. I understand that there may be additional uses or disclosures of my medical or health information that are specifically permitted by law without my Authorization, such as to government regulatory or law enforcement entities.

MassMutual FINANCIAL GROUP®

Massachusetts Mutual Life Insurance Company
1295 State Street, Springfield, MA 01111-0001

HIPAA Authorization

For use with Life, DI and Life with Long Term Care Riders

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A Authorizations

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- I hereby authorize the disclosure of my medical or health information to the Company, its service providers, its reinsurers and its agents, representatives and insurance producers (including the agents, representatives and employees of such persons or entities). I hereby authorize the disclosure of my medical or health information to any consumer reporting agency, including the MIB.
- I hereby authorize the use and disclosure of my medical or health information for purposes of and in connection with underwriting my application for insurance with the Company, determining the premium for the insurance, obtaining reinsurance, servicing my insurance and administering coverage, evaluating any claim for insurance benefits and conducting other legally permissible activities that relate to any coverage I have applied for. I understand that there may be additional uses or disclosures of my medical or health information that are specifically permitted by law without my Authorization, such as to government regulatory or law enforcement entities.

C State-Specific Authorizations

If you reside in a state listed below, then the identified provisions apply to your Authorization.

ARIZONA. With respect to disclosure of HIV-related information only, this Authorization is valid for 180-days from the date it is signed.

MAINE. This Authorization excludes the disclosure of the result of a test for HIV if the Insured has tested HIV positive but has not developed symptoms of the disease AIDS. Such test results shall not be discovered or published. Nothing in this caveat shall otherwise prohibit this Authorization from including other facts and information relative to the fact that the Insured has AIDS.

MINNESOTA. This Authorization excludes the release of information about HIV (AIDS Virus) tests which were administered (1) to a criminal offender or crime victim as a result of a crime that was reported to the police; (2) to a patient who received the services of emergency medical services personnel at a hospital or medical care facility; (3) to emergency personnel who were tested as a result of performing emergency medical services. The term "**emergency medical personnel**" includes individuals employed to provide pre-hospital emergency services; licensed police officers, firefighters, paramedics, emergency medical technicians, licensed nurses, rescue squad personnel, or other individuals who serve as volunteers of an ambulance service who provide emergency medical services; crime lab personnel, correctional guards, including security guards, at the Minnesota security hospital, who experience a significant exposure to an inmate who is transported to a facility for emergency medical care; and other persons who render emergency care or assistance at the scene of an emergency, or while an injured person is being transported to receive medical care and who would qualify for immunity under the Good Samaritan law.

NEW MEXICO. "Confidential abuse information" means information about acts of domestic abuse or abuse status, the work or home address or telephone number of a victim of domestic abuse or the status of an applicant or insured as a family member, employer or associate of a victim of domestic abuse or a person with whom an applicant or insured is known to have a direct, close personal, family or abuse-related counseling relationship. During the time this Authorization is valid it extends to the information required to determine eligibility for benefits under any policy issued as a result of this application.

With respect to confidential abuse information, this Authorization may be revoked in writing, ten days after receipt by the Company, but doing so may result in an application or claim being denied or may otherwise adversely affect a pending insurance action.

The Company may collect genetic information about you for use in conducting and administering its business of insurance. "Genetic information" means the information about a genetic makeup of a person or members of a person's family, including information resulting from genetic testing, genetic analysis, DNA composition, participation in genetic research or use of genetic services. This information may only be used, transmitted or retained for the purpose of conducting and administering its business of insurance, except with your consent or as otherwise authorized or required by law.

OREGON. With respect to disclosure of HIV-related information only, this Authorization is valid for 180-days from the date it is signed.

VERMONT. This Authorization does not extend to previously administered test for HIV anitbodies, T-Cell counts, AIDS or ARC, nor to any medical doctor, doctor of osteopathy, physician, health care professional, hospital, clinic, medical facility, the Veterans Administration, the MIB Inc., employer, consumer reporting agencies, other insurance company, or anyone else, with respect to previous test results. I am not providing authorization for the release of results from any new test for the HIV virus to any outside, non-affiliated company nor to any company not under contract with the company to perform underwriting services.

VIRGINIA. If this Authorization is used for claim purposes it is valid for the duration of the claim.

C State-Specific Authorizations

If you reside in a state listed below, then the identified provisions apply to your Authorization.

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MAINE. This Authorization excludes the disclosure of the result of a test for HIV if the Insured has tested HIV positive but has not developed symptoms of the disease AIDS. Such test results shall not be discovered or published. Nothing in this caveat shall otherwise prohibit this Authorization from including other facts and information relative to the fact that the Insured has AIDS.

MINNESOTA. This Authorization excludes the release of information about HIV (AIDS Virus) tests which were administered (1) to a criminal offender or crime victim as a result of a crime that was reported to the police; (2) to a patient who received the services of emergency medical services personnel at a hospital or medical care facility; (3) to emergency personnel who were tested as a result of performing emergency medical services. The term "**emergency medical personnel**" includes individuals employed to provide pre-hospital emergency services; licensed police officers, firefighters, paramedics, emergency medical technicians, licensed nurses, rescue squad personnel, or other individuals who serve as volunteers of an ambulance service who provide emergency medical services; crime lab personnel, correctional guards, including security guards, at the Minnesota security hospital, who experience a significant exposure to an inmate who is transported to a facility for emergency medical care; and other persons who render emergency care or assistance at the scene of an emergency, or while an injured person is being transported to receive medical care and who would qualify for immunity under the Good Samaritan law.

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