



MIB AUTHORIZATION AND REPORT FORM

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medical related facility, insurance company, MIB, LLC ("MIB") or other organization, institution or person, that has any records or knowledge of me or my health, to give to USAA Life Insurance Company, USAA Life Insurance Company of New York, (collectively, "Company") authorized third party administrator or its reinsurers, any such "information"

In connection with my life insurance application, I authorize the Company, its affiliates or designees, or its reinsurers to make a brief report of my "personal health information" or "protected health information" to MIB.

For purposes of this authorization, "information" means any records or knowledge concerning any person to be insured, of such person's health or mental condition, general character, driving record, and hobbies of a hazardous nature.

A facsimile of this authorization has the same force and effect as an original.

I have read and understand this authorization.

DATED AT _____ THIS _____ DAY OF _____, _____.
(city and state)

SIGNATURE OF PROPOSED INSURED OF BASIC POLICY (PARENT IF UNDER 15)

USAA NUMBER

Phone: 800-531-8722

USAA LIFE INSURANCE COMPANY 9800 Fredericksburg Rd San Antonio, TX 78288

97552-0422