NewBridge Life â HIPAA Authorization Form

DRAFT â FOR REVIEW PURPOSES ONLY

Policy Number: ________________________________

Policyholder Name: ____________________________

Date of Birth: ________________________________

Address: _____________________________________

City / State / ZIP: ____________________________

Phone: _______________________________________

Email: _______________________________________

Signature: ___________________________________

Date: ____

Please mail completed form to:
NewBridge Life
Attn: Policy Services
New York, NY

Or email: hello@newbridgelife.com