**AUTHORIZATION FOR RELEASE OF PENSION AND INDIVIDUAL ACCOUNT PLANS INFORMATION**

Participant Name: *(Print)* *{stdMbrFullName}*

Address: {stdMbrFUllAddress}

Home Telephone Number: {HomeNo.}



Work Telephone Number: {WorkNo.}

E-mail Address: {Email} Participant Birth Date:

*(Optional)*

**1. Description of Confidential Information I Authorize to be Used or Disclosed** (If left blank, this authorization form will apply to any and all information held by the MPI Pension and Individual Account Plans, including, but not limited to: Social Security numbers, addresses, dates of birth, etc.):

**2. Persons/Organizations Authorized to Receive My Confidential Information.**

I authorize the following person(s) and/or organization(s) (or classes of persons and/or organizations)

to receive my confidential information from the MPI Pension and Individual Account Plans:

(*Must give full name of person(s) and/or organization(s) authorized to receive information specified in #1 above.)*

**3. Expiration of This Authorization.** This Authorization will expire:

*(Choose and complete one)*

a. On

*(MM / DD / YYYY)*

b. Upon the occurrence of the following event(s):

**4. Signature**

*(For example: At the conclusion of a Trial, Divorce, etc.)*

I, {stdMbrFullName}

*(Please print Participant’s name)*, have had an

opportunity to review and understand the contents of this form. By signing this form, I am confirming that it accurately reflects my wishes.

*Participant’s Signature Date*

**In all instances, this Authorization will expire upon the death of the authorizing Participant or Beneficiary.**

THIS AUTHORIZATION MUST BE COMPLETED IN FULL IN ORDER TO BE EFFECTIVE

*Return completed form to:*

Pension Benefits Department c/o MPIPHP , P.O. Box 1999, Studio City, California 91614-0999