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

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

Address: {stdMbrFUllAddress}

Home Telephone Number: {x HomeNo}



Work Telephone Number: {x WorkNo}

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

*(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 Motion Picture Industry Pension Plan (the “Pension Plan”) and the Motion Picture Industry Individual Account Plan (the “IAP”) (collectively, “MPI”), 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 Pension Plan and the IAP:

(*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:*

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