



AUTHORIZATION FOR RELEASE OF PENSION AND INDIVIDUAL ACCOUNT PLANS INFORMATION

Print Participant's Name: _____ Participant's SSN: _____

Address: _____

Home PH: _____ Work PH: _____

E-mail Address: _____ 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 and/or Disclose 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 / YR
- b) Upon the occurrence of the following event(s):

(For example: At the conclusion of a Trial (attorney), Divorce (for spouse), etc.)

In all instances, this Authorization will expire upon the death of the Authorizing party (i.e. participant/beneficiary)

4. Signature

I, _____ (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

Date

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

**RETURN COMPLETED FORM TO: PENSION DEPARTMENT
% MPIP
P.O. Box 1999
STUDIO CITY, CA 91614-0999**