

# Producer-Writers Guild of America Pension Plan

Terence L. Young, Chief Executive Officer

## Authorization to Release Information

The Participant should complete this form, only if the Participant would like to authorize a person or entity to receive Pension information on his/her behalf. *Unless this form is returned (signed and dated by the Participant), information will not be released to any unauthorized third party.* This authorization will remain in effect until such time that the Participant notifies the Administrative Office in writing. A photocopy of this form will be treated as an original, with the full force and power of said original.

<b>SECTION 1 PARTICIPANT INFORMATION</b>	
Please print or type the information below for the Participant.	
NAME	SOCIAL SECURITY NUMBER OR UNIQUE IDENTIFIER

<b>SECTION 2 AUTHORIZED THIRD PARTY INFORMATION</b>		
Please print or type the information below for the third party authorized to receive Pension information on behalf of the Participant.		
NAME OF INDIVIDUAL OR ENTITY	ALL INDIVIDUALS REPRESENTING ENTITY OR INDIVIDUAL NAMES (CHECK ONLY ONE AND LIST, IF APPLICABLE)	
 	<input type="checkbox"/> ALL INDIVIDUALS REPRESENTING ENTITY, OR <input type="checkbox"/> ONLY THE FOLLOWING INDIVIDUALS:	
STREET ADDRESS		
CITY	STATE	POSTAL CODE
TELEPHONE NUMBER	FAX NUMBER	E-MAIL ADDRESS
ADDRESS INFORMATION RELATIVE TO PARTICIPANT (PLEASE CHECK THE BOX BELOW TO INDICATE THAT THE ADDRESS ON RECORD FOR THE PARTICIPANT SHOULD BE UPDATED. IF THE BOX IS NOT CHECKED, THEN THE PARTICIPANT'S ADDRESS WILL NOT BE UPDATED.)		
<input type="checkbox"/> UPDATE THE PARTICIPANT'S ADDRESS ON RECORD FOR PENSION PURPOSES TO THE ADDRESS IN THIS SECTION 2.		

<b>SECTION 3 PARTICIPANT'S ACKNOWLEDGEMENT</b>		
I, the Participant, authorize the individual or entity in Section 2 to receive Pension information from the Producer-Writers Guild of America Pension Plan (the "Plan") and that the Plan may act under this authorization upon receipt. I agree to hold the Plan harmless from any claims that may arise against the Plan because of the Plan's reliance on this authorization. I understand that this authorization will remain in effect unless and until I notify the Administrative Office in writing.		
NAME	DATE	SOCIAL SECURITY NUMBER OR UNIQUE IDENTIFIER



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