Participant's Name _____ Local _____ Reg.No. _____

AUTHORIZATION TO RELEASE INFORMATION

☐ ILWU-PMA Pension Plan

☐ ILWU-PMA Watchmen Pension Plan

☐ ILWU-PMA Welfare Plan

The undersigned hereby authorizes the Trustees of the Plans identified above to release to:

_____

_____

_____

any and all information, including medical information, maintained by the Trustees in connection with my participation in such Plan(s). I understand that this authorization is a waiver of my rights to privacy under law as to such information.

Signed _____

this _____ day of _____, 200_

Mail to: **ILWU-PMA Benefit Plans**
1188 Franklin Street, Suite 101
San Francisco, CA 94109