MEBA PENSION TRUST
APPLICATION & INSTRUCTIONS FOR PENSION BENEFITS

INSTRUCTIONS

A. Complete ALL information on the reverse side of this Application. Please be sure to sign & date the Application where indicated.

B. Complete and attach the following forms to your application. If any of these forms are missing from your application packet, please ask your Branch Agent or Representative to give you the missing forms or request such forms from the Plan Office in Baltimore. You may also visit the Plan Office website at www.mebaplans.org to obtain these forms.

1. Declaration of Retirement
2. Permanent Data Form No. 2
3. Proof of Total and Permanent Disability
4. Health Information Authorization Form

C. Attach the following documents to your Application (Please disregard if these documents have been submitted to us previously):

1. Birth or Baptismal Certificate for both you and your spouse.
2. Marriage Certificate.
3. Proof of your most recent employment for six months prior to filing this Application (e.g. Coast Guard Discharges, Pay Vouchers, etc.).
4. Discharges or other evidence of all maritime service as a Licensed Officer prior to 1956, including all MSTS employment, past and present.
5. Proof of all military service since 1940 (discharge papers of Form DD214).
6. Proof of any disability periods for which you received disability benefits from a State Disability Plan.

D. All sailing time should be completed & you should file for any vacation time before the Pension Application deadline. This will ensure that your benefit will be processed for the next Board of Trustees' meeting.

E. If you have not completed all of your sailing time, submitted all of your vacation time and/or school time by the Application deadline, your pension claim may not be eligible for submission to the next Board of Trustees' meeting. However, your claim will be submitted to the following Board of Trustees meeting.

F. When you have completed the above steps, mail your application and all required documents to the Plan Office, or file your Application in person at your local MEBA Branch Office in Baltimore, Houston, New Orleans, Jersey City, Philadelphia, Oakland, Seattle, or Wilmington, California.

NOTE: THE PLAN OFFICE MAY REQUEST THAT YOU FURNISH ADDITIONAL FORMS NECESSARY TO COMPLETE YOUR APPLICATION. THESE FORMS WILL BE MAILED TO YOU AS NEEDED. IT IS EXTREMELY IMPORTANT THAT YOU KEEP THE PLAN OFFICE ADVISED OF YOUR MAILING ADDRESS DURING THE APPLICATION PROCESS.

MEBA Pension Trust 1007 Eastern Avenue Baltimore, MD 21202-4345
410-547-9111 * 800-811-MEBA (Toll-Free) * 410-659-1675 (Fax) * www.mebaplans.org

APPLICATION FOR PENSION BENEFITS

Member Name	*Last Name* *First Name* *Initial*
Social Security Number	☐☐☐-☐☐-☐☐☐☐
Date of Birth	/ / *Month* *Day* *Year*
Telephone Number	☐☐☐ - ☐☐☐ - ☐☐☐☐
Permanent Address (Home of Record) **New Address?** ☐ yes ☐ no	*Number and Street* *City* *State* *Zip*
Mailing Address **(If Other than Permanent Address)**	*Number and Street* *City* *State* *Zip*
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Other	**Spouse's Name:** **Spouse's Birth Date:** **Spouse's SS#:**

Date You Wish Pension Benefits to Commence: ***(NOTE: Under the Plan Regulations, your earliest Effective Date of Pension is the first of the month following the later of: (1) the date this Application is filed, or (2) the date you cease all Covered Employment and complete your last Vacation period.)***	

Are You Applying for a Disability Pension? **Be advised that Disability Pensions are subject to an annual earned income limitation of $36,000.**	☐ Yes ☐ No

Are you presently receiving Disability Benefits from the MEBA Medical and Benefits Plan?	☐ Yes ☐ No
If YES, note that you may not receive Disability benefits from the Medical Plan and Pension benefits from the MEBA Pension Trust concurrently. Therefore, please check one of the following:	☐ **I wish to have my Pension Benefits commence after my Disability Benefit payments end.** ☐ **I wish to have all Disability Benefit payments for periods after my Pension Effective Date deducted from my first Pension check (and repaid to the MEBA Medical Plan).**

Have you ever been covered by another maritime pension plan, or governmental or military plan?	☐ Yes ☐ No
If yes, specify name(s) of the plan(s) and the monthly amount(s) you are receiving or are entitled to receive. Also indicate if you have received a lump sum distribution:	

I hereby certify that all the information in this Application and my Declaration of Retirement from the Maritime Industry is true and correct to the best of my knowledge and belief and that all documents included with my Application for Pension Benefits are bonafide originals or true copies of the originals. I understand that a false statement could adversely affect my Pension Benefits and subject me to criminal and/or civil sanctions.

______________________________ ______________________

APPLICANT'S SIGNATURE DATE

REV 2010-04

Declaration of Retirement from the Maritime Industry

TO: The Trustees of the MEBA Pension Trust (the "Plan")

I hereby certify that I have withdrawn from any employment aboard any vessel and from any other employment referred to in Sections 1.21 and 1.34 of the Plan Regulations, which I have read. I also certify that I have taken all of my accrued vacation benefits.

If at a subsequent time, I return to such employment referred to in Sections 1.21 and 1.34 without written permission of the Plan's Trustees, I will be subjected to the penalties outlined in Section 2.09 of the Plan Regulations. (The provisions of Sections 1.21, 1.34 and 2.09 are summarized in the Plan Regulations. Also see pages 19-22 of the MEBA Pension Trust Summary Plan Description and the attached *Statement of All Pensioners' Rights to Return to Employment in the Maritime Industry*.) I understand that if the Trustees bring suit to enforce the Plan Regulations and prevail, they are entitled to recover attorney's fees, costs, and interest from me as permitted by law. Nothing in the Plan Regulations, however, prohibits my returning to employment in the Maritime Industry.

Enter the Date of Your Last Employment Below (One Only):

Type of Employment	Date
Sailing	
School	
Night/Port Relief	
Port Engineer, Port Electrician Or Hull Inspector	

Enter the Date of Your Last Vacation Below:

Last Date of Vacation	

SIGNATURE: ______________________________ **DATE:** ________________

PRINT NAME: ______________________________ **SSN:** ____________________

RELATIVE VALUE OF BENEFIT PAYMENT OPTIONS

IRS Regulations require plans, such as ours, to give retiring participants a comparison of the relative values of the benefit payment options generally available under the Plan. The aim is to help individuals make informed choices about the form in which you receive your retirement benefits. Relative value means the actual present value of each optional form of payment to the value of the Qualified Joint and 50% Survivor Annuity.

In our case, the benefit payment options that the MEBA Pension Trust makes generally available to its retiring participants have approximately the same actuarial value for a participant who is the same age as his or her spouse and who is retiring at ages 40, 45, 50, 55, 60 or 65. This conclusion is based on the valuation and reporting methodologies described in the IRS Regulation, which can be found at Treasury Regulations Section·1.417(a)(3)-1. Upon your written request, we will give you a similar comparison based on your own age and estimated benefits, and on any other payment forms for which you are eligible.

As noted, the relative values are based on comparing the actuarial values of the Life Annuity benefit payment option, the Joint and 50% Survivor Annuity with Pop-up benefit payment option, the Joint and 75% Survivor Annuity benefit option, the Joint and 100% Survivor Annuity benefit payment option, and the Joint and 100% Survivor Annuity with Pop-up benefit payment option to the actuarial value of the Qualified Joint and 50% Survivor Annuity benefit payment. This comparison is intended to allow you to compare the total value of different forms. It is made by converting the value of each optional form to a common form using interest and life expectancy assumptions. Although the comparisons are based on average life expectancies, the relative value of payments ultimately made under an annuity option depends on actual longevity. The assumptions used for this comparison are the segmented interest rate yield curve using 0.96% for the first five years, 3.5% for the 6th through 20th years and 4.52% for years after, and the rate of 7.5% and the 1971Mortality Table for males, set back 5 years for females.

For additional information, please send a written request to MEBA Benefit Plans, 100 Eastern Avenue, Baltimore, MD 21202.

Instructions for Completing Permanent Data Forms

You must complete a Permanent Data Form if you are a new Participant, if you are adding a Dependant, if your marital status changes, or if your dependant's eligibility status changes.

The following documents must be included with your completed Permanent Data Form:

Married

- If you are married – a copy of your marriage certificate.
- If your spouse has other coverage, please forward a copy of your spouse's medical/dental/optical insurance card(s), so that the Plan can properly coordinate benefits.

Children

- Biological children – a copy of each child's birth certificate.
- Adopted children – a copy of each child's adoption papers and birth certificate.
- Stepchildren – a copy of each child's birth certificate, a copy of your most recent IRS tax filing, a copy of that part of your spouse's divorce decree that assigns responsibility for the stepchild's medical care.
- Grandchildren - a copy of each child's birth certificate, proof of legal custody awarded by a court or state agency, a copy of your most recent IRS tax filing, (additional documentation may be required).

Dependant Parents

- Dependant Parents – a copy of your most recent IRS tax filing as proof that you claim your parent as a dependant on your tax return. You will be required to provide proof of support of your parent(s) annually.

Your parent(s) may be covered as a dependant only if:

(1) you do not have a spouse, you do not have natural or adopted children under the age of 26, and you do not have stepchildren under age 19 (or 23, if full-time students); and

(2) you contribute at least one-half of the support of the parent being claimed as a dependant, claim your parent as a dependant on your IRS tax return, and you submit a copy of your most recent IRS tax filing as proof of support.

Additional Requirements for Adult Children (over age 18)

Biological and Adopted Children Age 19 through 25

- Your biological and adopted adult children under the age of 26 may be covered as a dependant.

Stepchildren and Grandchildren

- Your stepchildren and grandchildren age 19 through age 22 may be covered as a dependant provided they are full-time students.
- Student status forms are available from the Plan Office or on the Plan website (www.mebaplans.org).
- You are required to verify full-time student status for each stepchild and/or grandchild each year.

If you or any of your dependents are eligible for Medicare, you must provide a copy of you and/or your dependent's Medicare card.

Change in Marital Status

Marriage

- If you are single and become married, you must notify the Plan Office and submit a copy of your marriage certificate with your new Permanent Data Form to enroll your new spouse.

Divorce or legal separation

- If you are married and become divorced or legally separated, you must notify the Plan Office immediately and submit a copy of your divorce decree, legal separation agreement or your written agreement to live separately within 30 days, along with your new Permanent Data Form.

- If you are divorced and are keeping your children as dependants in the Plan, you must provide additional information about other coverage the children may have, such as through your former spouse (or his or her new spouse, if remarried), so that the Plan can properly coordinate benefits. If included in your divorce decree, a copy of the portion that assigns responsibility for medical care may be needed to determine order of payment.

Address and Address Changes

- If you use a PO Box as either your permanent address or your mailing address, you must also provide a physical address.
- If you are advising the Plan of a change of address only and have no other changes to make you can complete a new Permanent Data Form or you can simply notify the Plan Office in writing of the address change. Include your name and social security number. The Participant must sign this notification in order to allow the Plan Office to change your address.

IMPORTANT - When Coverage Terminates

If you and/or your dependant no longer meet the eligibility requirements your coverage and/or your dependant's coverage will end. You are required to notify the Plan Office in writing and within 30 days of events that impact your and/or your dependant's eligibility under the Plan. Events that may lead to ineligibility and a loss of coverage under the Plan include, but are not limited to:

- Failure to report a divorce;
- Failure to report a legal separation;
- Failure to report a child's eligibility for other coverage, including the availability of such coverage;
- For stepchildren and grandchildren, failure to report a change in student status, a change in residency or a change in support;
- For stepchildren and grandchildren, failure to report a child's marriage;
- For grandchildren, failure to meet the grandchild eligibility rules; and
- Failure to pay any required premiums (e.g., COBRA, pensioner contributions, Alternate Plan premiums) timely.
- For Pensioners, return to work under certain circumstances without the permission of the Trustees.

If you do not timely notify the Plan Office of an event that causes a change in your or your dependant's eligibility under the Plan, you will be required to reimburse the Plan for benefits that were paid after your and/or your dependant's coverage terminated.

In addition, your or your dependant's coverage under the Plan may be terminated retroactively in the case of fraud or intentional misrepresentation.

MEBA Medical & Benefits Plan 1007 Eastern Avenue Baltimore, MD 21202-4345
410-547-9111 * 800-811-MEBA (6322) * 410-547-6665 (Fax) * www.mebaplans.org

PERMANENT DATA FORM

COMPLETE BOTH PAGES OF THIS FORM , SIGN AND DATE WHERE INDICATED, AND RETURN TO THE PLAN OFFICE IN BALTIMORE

Member Name	Last Name First Name Initial		
Social Security Number			
Date of Birth (mm/dd/yyyy)		Sex (Select one)	○ Male ○ Female
Home Telephone Number	(Area Code:)		
Cellular Phone Number	(Area Code:)		
E-mail address (If applicable)	@		
Affiliation (Check One)	○ District No. 1-PCD, MEBA ○ Plan Employee ○ Union Employee ○ Other:		
Active/Pensioner (Check One)	○ Active ○ Pensioner	If Actively Employed, Name of Present Employer:	
Marital Status (Check One)	○ Single ○ Married ○ Widowed ○ Divorced ○ Legally Separated		
Date Married, Widowed, Divorced or Legally Separated (mm/dd/yyyy)		○ Married ○ Widowed ○ Divorced ○ Legally Separated	
Permanent Address (Home of Record):	Number & Street		
	City, State, Zip		
Mailing Address (if different than Permanent Address above):	Number & Street		
	City, State, Zip		

DEPENDANTS TO BE ADDED TO YOUR MEDICAL COVERAGE (LIST FULL NAMES)

LAST NAME FIRST NAME INITIAL	DATE OF BIRTH (MM/DD/YYYY)	DEPENDANT SSN	RELATIONSHIP TO MEMBER CHECK ONE	STEP/GRAND CHILD CHECK IF FT STUDENT
			○ Spouse ○ Child ○ Adopted Child ○ Stepchild ○ Grandchild	○ Yes ○ No

If dependant is an adult child/adopted child, is he or she eligible for Employment Based Coverage? (check one) ○ Yes ○ No..
If eligible for Employment Based Coverage, complete the following sections

Child's Employer Name	Child's Employer Address	Child's Employer Phone
Child's Spouse's Employer Name	Child's Spouse's Employer Address	Child's Spouse's Employer Phone

Revised 01/2014

LAST NAME FIRST NAME INITIAL	DATE OF BIRTH (MM/DD/YYYY)	DEPENDANT SSN	RELATIONSHIP TO MEMBER CHECK ONE		STEP/GRAND CHILD CHECK IF FT STUDENT
			○ Child ○ Stepchild	○ Adopted Child ○ Grandchild	○ Yes ○ No
If dependant is an adult child/adopted child, is he or she eligible for Employment Based Coverage? (check one) ○ Yes ○ No.. **If eligible for Employment Based Coverage, complete the following sections**					
Child's Employer Name	Child's Employer Address		Child's Employer Phone		
Child's Spouse's Employer Name	Child's Spouse's Employer Address		Child's Spouse's Employer Phone		

LAST NAME FIRST NAME INITIAL	DATE OF BIRTH (MM/DD/YYYY)	DEPENDANT SSN	RELATIONSHIP TO MEMBER CHECK ONE		STEP/GRAND CHILD CHECK IF FT STUDENT
			○ Child ○ Stepchild	○ Adopted Child ○ Grandchild	○ Yes ○ No
If dependant is an adult child/adopted child, is he or she eligible for Employment Based Coverage? (check one) ○ Yes ○ No.. **If eligible for Employment Based Coverage, complete the following sections**					
Child's Employer Name	Child's Employer Address		Child's Employer Phone		
Child's Spouse's Employer Name	Child's Spouse's Employer Address		Child's Spouse's Employer Phone		

LAST NAME FIRST NAME INITIAL	DATE OF BIRTH (MM/DD/YYYY)	DEPENDANT SSN	RELATIONSHIP TO MEMBER CHECK ONE		STEP/GRAND CHILD CHECK IF FT STUDENT
			○ Child ○ Stepchild	○ Adopted Child ○ Grandchild	○ Yes ○ No
If dependant is an adult child/adopted child, is he or she eligible for Employment Based Coverage? (check one) ○ Yes ○ No.. **If eligible for Employment Based Coverage, complete the following sections**					
Child's Employer Name	Child's Employer Address		Child's Employer Phone		
Child's Spouse's Employer Name	Child's Spouse's Employer Address		Child's Spouse's Employer Phone		

(Attach a separate sheet to your Permanent Data Form if you have more than four Dependants)

Signature of Employee		Date	

FORM IS NOT VALID IF NOT SIGNED AND DATED BY PARTICIPANT
FORM WILL BE RETURNED IF NOT SIGNED AND DATED.

Revised 01/2014

Instructions for Completing Beneficiary Designation Form

You must complete a Beneficiary Designation Form if you are a new Participant in the Plan or if you are changing your beneficiary for life insurance.

Changing Your Beneficiary for Life Insurance

- A new Beneficiary Designation Form must be completed in its entirety.
- The Beneficiary Designation Form **must be signed** for the change of beneficiary to become effective.

MEBA Medical & Benefits Plan 1007 Eastern Avenue Baltimore, MD 21202-4345
410-547-9111 * 800-811-MEBA (6322) * 410-547-6665 (Fax) * www.mebaplans.org

BENEFICIARY DESIGNATION FORM

COMPLETE BOTH PAGES OF THIS FORM , SIGN AND DATE WHERE INDICATED, AND RETURN TO THE PLAN OFFICE IN BALTIMORE

Member Name	Last Name	First Name	Initial
Social Security Number			
Date of Birth (mm/dd/yyyy)		Sex (Select one)	○ Male ○ Female
Home Telephone Number	(Area Code:)		
Cellular Phone Number	(Area Code:)		
E-mail address (If applicable)	@		
Affiliation (Check One)	○ District No. 1-PCD, MEBA ○ Plan Employee ○ Union Employee ○ Other:		
Active/Pensioner (Check One)	○ Active ○ Pensioner	If Actively Employed, Name of Present Employer:	
Marital Status (Check One)	○ Single ○ Married ○ Widowed ○ Divorced ○ Legally Separated		

BENEFICIARY DESIGNATION FORM

I designate the following person(s) as my beneficiary (ies) to receive benefits which may be payable from the MEBA Medical and Benefits Plan upon my death. I revoke all previous beneficiary designations and make the designation of beneficiary(ies) shown below with respect to benefits provided now or at any time in the future under the above Plan, still reserving to myself the privilege of making other and future changes subject to the Plan provisions. If more than one beneficiary is designated, settlement will be made in equal shares to such of the designated beneficiaries (or beneficiary) as survive me, unless otherwise provided herein (total must equal 100%). If no beneficiary survives me, settlement will be made in accordance with the provisions of the Plan. **NOTE: Co-beneficiaries receive proceeds in equal shares, unless otherwise indicated. Contingent Beneficiary is the person who will receive the proceeds if the primary beneficiary should predecease the person whose life is insured.**

Name: **Check One:** ☐ Beneficiary ***or*** ☐ Co-Beneficiary	Last Name	First Name	Initial	Relationship
Address of Beneficiary	Number & Street	City	State	Zip
Beneficiary's Social Security Number		Percent (%) of Benefit:	_______%	
Date of Birth (mm/dd/yyyy)		Sex (Check One)	○ Male ○ Female	

Revised 12/2010

CO-BENEFICIARY (IES) OR CONTINGENT BENEFICIARY (IES)

Name: **Check One:** ☐ Beneficiary ***or*** ☐ Co-Beneficiary	Last Name	First Name	Initial	Relationship
Address of Beneficiary	Number & Street	City	State	Zip
Beneficiary's Social Security Number		Percent (%) of Benefit:	_______%	
Date of Birth (mm/dd/yyyy)		Sex (Check One)	○ Male ○ Female	
Name: **Check One:** ☐ Co-Beneficiary ***or*** ☐ Contingent Beneficiary	Last Name	First Name	Initial	Relationship
Address of Beneficiary	Number & Street	City	State	Zip
Beneficiary's Social Security Number		Percent (%) of Benefit:	_______%	
Date of Birth (mm/dd/yyyy)		Sex (Check One)	○ Male ○ Female	

Name: **Check One:** ☐ Co-Beneficiary ***or*** ☐ Contingent Beneficiary	Last Name	First Name	Initial	Relationship
Address of Beneficiary	Number & Street	City	State	Zip
Beneficiary's Social Security Number		Percent (%) of Benefit:	_______%	
Date of Birth (mm/dd/yyyy)		Sex (Check One)	○ Male ○ Female	

(Attach a separate sheet to your Permanent Data Form if you have more than two Co-Beneficiaries)

Signature of Employee		Date	

FORM IS NOT VALID IF NOT SIGNED AND DATED BY PARTICIPANT
FORM WILL BE RETURNED IF NOT SIGNED AND DATED.

Revised 12/2010

MEBA PENSION TRUST
1007 EASTERN AVENUE
BALTIMORE, MD 21202-4345
(800) 811-MEBA

PROOF OF TOTAL AND PERMANENT DISABILITY

This form should be completed only if you are applying for a Disability Pension. Be advised that Disability Pensions are subject to an annual earned income limitation of $36,000.

NAME ____________________ SOCIAL SECURITY NUMBER ____________________

PART A. TO BE COMPLETED BY CLAIMANT (complete questions 1 through 8 and ask your doctor to complete PART B – Attending Physician's Section)

1. Are you presently employed in any capacity? ○ YES ○ NO
   If yes, in what capacity? ____________________
   If no, when did you cease employment? ____________________
2. What was the last date you worked in the Maritime Industry? ____________ (Date)
3. On what date do you feel you can resume any type of work? ____________ (Date)
4. Explain the nature of your disability. ____________________
5. When did this disability occur? ____________ (Date)
6. Were you able to work for any period after the onset of the disability? ○ YES ○ NO
7. Have you applied for or received a Social Security Disability Award? ○ YES ○ NO
   If you applied but have not yet received your award certificate, give date of application. ____________ (Date)
8. If you have had an examination at a MEBA Diagnostic Center, indicate the date and location of your last examination and complete the attached authorization for release of health information.

DATE OF LATEST DIAGNOSTIC CENTER EXAMINATION:

DIAGNOSTIC CENTER LOCATION AT WHICH YOU WERE EXAMINED:

Month	Year	City	State

PART B. TO BE COMPLETED BY ATTENDING PHYSICIAN (complete questions 9 through 23 and return this form directly to the MEBA Pension Trust at 1007 Eastern Avenue, Baltimore, MD 21202)

9. In your medical opinion, will the patient be able to return to his current employment in the Maritime Industry?
   ○ YES ○ NO If yes, when? _______________ (Date)

10. In your medical opinion, will the patient be able to be gainfully employed in any other type of employment?
    ○ YES ○ NO If yes, when? _______________ (Date)

11. Please indicate the date on which the patient became permanently and totally disabled. _______________ (Date)

12. Please indicate the first date on which you began treatment of this patient for this disability. _______________ (Date)

13. Has this disability been continuous? ○ YES ○ NO

14. In what way is this patient disabled? Please describe: ____

15. What is your diagnosis of this disability? ____

16. Is treatment for the disability currently being provided? ○ YES ○ NO
    If yes, describe the treatment: ____

17. What is the patient's response to the treatment? ____

18. Was the patient confined to a hospital during any period of this disability? ○ YES ○ NO
    If yes, for how long? ______________________ Date(s) of hospitalization _________________________ Date(s)

19. Is the patient confined to a bed? ○ YES ○ NO
    Is the patient in anyway confined indoors? ○ YES ○ NO
    If yes, please describe the circumstances: ____

20. Did the patient have surgery? ○ YES ○ NO If yes, on what date: _______________ (Date)
    Please describe surgery: ____

21. Is the patient mentally capable of transacting personal affairs, such as endorsing checks with the realization of the nature and consequences of his or her acts? ○ YES ○ NO

22. Remarks: ____

23. Please respond below if this disability is due to a cardiac condition:
    a. Functional Capacity (American Heart Association)
       ○ Class 1 (No Limitation) ○ Class 2 (Slight Limitation) ○ Class 3 (Marked Limitation) ○ Class 4 (Complete Limitation)
    b. Blood Pressure Systolic __________________ Diastolic ________________

Physician's Signature: ____ Dated: _________________________

Address: ____

Degree: ____________ Year: _______ State License #: _________________ Employer ID #: ____________

REV 2008-03

MEBA
Benefit Plans
Safeguarding MEBA Members and Families

1007 Eastern Avenue
Baltimore, Maryland 21202-4345
Phone (410) 547-9111
www.mebaplans.org

Authorization for the Use and Disclosure of Protected Health Information

MEBA Medical & Benefits Plan
1007 Eastern Avenue
Baltimore, MD 21202
(800) 811-6322

As required by the Health Information Portability and Accountability Act of 1996 the MEBA Medical & Benefits Plan may not use or disclose your health information except as provided in our Notice of Privacy Practices without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosures described herein. You may revoke this authorization at any time by signing and dating the revocation section on your copy of this form and returning it to this office.

AUTHORIZATION SECTION

I, ________________________________ (print name) hereby authorize the use and disclosure of the following health information that pertains to me:

my most current Diagnostic Center Examination

For the following purpose<s>:

review of my Statement of Health submitted to the MEBA Pension Trust

I authorize the following persons to make these disclosures of my health information:

Diagnostic Center staff

I authorize the following persons to receive these disclosures of my health information:

MEBA Pension Trust and/or designee for review of Statements of Health

I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties and no longer protected.

I understand that I may revoke this authorization at any time by signing the revocation section of my copy of this form and returning it to the attention of the Privacy Official at the address noted on page one of this form. I further understand that any such revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this authorization.

I understand that this authorization will automatically expire after review of my Statement of Health.

I understand that I am under no obligation to sign this authorization. I further understand that my eligibility for benefits will not depend in any way on whether I sign this authorization or not.

I understand that I have a right to inspect and to obtain a copy of any information disclosed pursuant to this authorization.

______________________________ Signature

______________________________ Date

REVOCATION SECTION

I hereby revoke this authorization.

______________________________ Signature

______________________________ Date