

INSTRUCTIONS

This Authorization Form should be completed if you choose to designate an authorized representative to obtain information about your pension benefit, earnings and additional information maintained by the Fund. This form is not required in the event you have previously submitted a Power of Attorney ("POA") form which names the person(s) or organization you wish to authorize. **You must sign the form on page 2 and have your signature notarized by a Notary Public.**

To begin the process of adding an authorized representative, you must complete, sign, date and mail the Form to:

AFTRA Retirement Fund
Attention: Retirement Services Department
261 Madison Avenue, 7th Floor
New York, NY 10016

All sections must be completed fully and accurately for your Authorization Form to be processed by the AFTRA Retirement Fund.

PARTICIPANT INFORMATION**Legal Name**

Last Name _____ First Name _____ Middle Name _____

Social Security No. _____

PERSON AND ORGANIZATION AUTHORIZED TO RECEIVE INFORMATION

I, _____, hereby give consent to the authorized person or organization listed below to:

Please check all that apply

☐ Inquire about my earnings information and benefits

☐ Update/change my personal information.

ADDRESS INFORMATION FOR AUTHORIZED REPRESENTATIVE**Person Authorized**

Last Name _____ First Name _____ Middle Name _____

Organization of Authorized Person (if applicable) _____

Address Line 1 _____ Apt/Unit/Suite/Floor _____

Address Line 2 _____

City _____ State/Province _____ ZIP Code _____ Country _____

Email Address _____ Relationship to the performer or benefit recipient _____

Home Telephone No. (XXX) XXX-XXXX _____ Cell Telephone No. (XXX) XXX-XXXX _____

AUTHORIZATION CONFIRMATION

You must read and complete the required fields below in order for the Fund to review and process your Form.

I, _____, understand that by completing this Authorization Form, this form will remain on file with the Fund until either of the following actions take place:

- The Fund receives a written request to revoke the designee, OR
- The Fund receives a new Authorization Form with a newly designated representative, which will be considered the new form on file.

Participant or Benefit

Recipient's Signature _____ Date (MM/DD/YYYY) _____

STATE OF _____ COUNTY OF _____

On this day of _____, 20_____, the individual named above, to me personally known (or proved to me on the basis of satisfactory evidence) to be the individual described herein, personally appeared before me and executed the foregoing statement or acknowledged to me that they executed the same.

Notary Public Signature _____ Date (MM/DD/YYYY) _____

Notary Stamp/Seal

