NORTHERN CALIFORNIA PIPE TRADES ("NCPT") TRUST FUNDS FOR UA LOCAL 342

AUTHORIZATION FOR RELEASE OF INFORMATION

Please note the execution of this Form does not authorize release of information other than that specifically described below.

I. INFORMATION ABOUT THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION AND RETIREMENT BENEFIT INFORMATION

Participant/Retiree/Alternate Payee Name: _____ Social Security No. xxx-xx-_____

I, (Participant/Retiree/Dependent/Alternate Payee Name) _____, hereby authorize the use or disclosure of my written, electronic, and oral benefit information as described below.

1. Specify the individual /organization authorized to receive your benefit information (e.g. Spouse, Child, Parent, etc.) and check the box(es) immediately below the individual / organization's name to specify the Fund(s) you are authorizing release of information on.

Name: _____ Phone Number: (___)_____ Relationship: *_____

- ❒ Protected Health Information ("PHI") for the NCPT Health and Welfare Trust Fund.
- ❒ Retirement Benefit Information for the NCPT Pension Trust Fund.

Name: _____ Phone Number: (___)_____ Relationship: *_____

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- ❒ Retirement Benefit Information for the NCPT Pension Trust Fund.

* *Any change in life circumstances that alters the relationship you have listed may invalidate this authorization.*

2. Check the applicable box(es) below to specify the NCPT Plan authorized to provide information:
   - ❒ Northern California Pipe Trades Health and Welfare Trust Fund
     (*This applies without restriction, only to benefits administered at the Trust Fund Office.*)
   - ❒ Northern California Pipe Trades Pension Trust Fund
     (*This applies without restriction, only to benefits administered at the Trust Fund Office.*)
   - ❒ Specify if limiting authority:_____
     _____
3. Check the applicable box below to describe the information you authorize the Trust Fund Office Staff to disclose:
   - ❑ All benefit matters including, but not limited to, eligibility, claims for benefits, dues statements, and appeals of the denial of benefits, financial information, and any other indebtedness or obligation incurred by Participant or on Participant's behalf; **or**
   - ❑ If limiting authority, specific circumstance or limited information to be disclosed:_____
     _____
4. Check the applicable box below for the purpose of this request:
   - ❑ To discuss benefits with the Trust Fund Office so I can better understand my benefits; **or**
   - ❑ At the request of the individual(s) / organization(s) listed in item 1 above.
5. This authorization will expire on:
   - ❑ Indefinitely; **or**
   - ❑ Specified Date: _____

II. IMPORTANT INFORMATION ABOUT YOUR RIGHTS – I have read and understand the following statements about my rights:

- I understand that I have the right to revoke this authorization at any time by notifying the Trust Fund Office in writing. I understand that the revocation is only effective after it is received and processed by the Trust Fund Office. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation.
- I understand that after this information is disclosed, federal law might not protect it and the recipient might disclose it again.
- I understand that the Trust Fund Office will not be held responsible for the release and subsequent use of the information.
- I understand that I am entitled to receive a copy of this authorization. (Please retain a copy for your records.)
- I understand the Plan will not condition enrollment, eligibility, or payment of benefits on receipt of an authorization.
- I understand that if I have authorized my spouse to receive information, this authorization will be invalidated upon notification to the Trust Fund Office of a separation in any form or divorce.
- I understand that this authorization supercedes and overrides any previous authorization(s) I have submitted.

The refusal to sign this authorization will not affect your ability, according to the Plan's provisions, to receive payment of benefits or eligibility for benefits unless authorized by law. All member documents and personal information is strictly confidential and will not be shared with others without your authorization. The Authorization for Release of Information Form allows the Trust Fund Office to release specific information authorized by you to another person or organization.

III. SIGNATURE (PARTICIPANT/RETIREE/DEPENDENT/ALTERNATE PAYEE):_____DATE:_____

Please return this Form to: Kim Biagi
NCPTTF Privacy Officer
935 Detroit Avenue, Suite 242A
Concord, CA 94518-2501

Phone: 925/356-8921
Fax: 925/356-8938
Email: *tfo@ncpttf.com*