



## Authorization to Discuss Member Information

*This form must be signed by the Member and notarized, to allow ERFC representatives to speak to the individual(s) listed below regarding the Member's ERFC retirement benefits and general account information. This form does not allow the individual(s) listed below to take any actions that affect the Member's ERFC account. Completion of this form does not allow ERFC representatives to discuss any of the following types of information with anyone other than the Member: Bank or Credit Union accounts or routing numbers, beneficiary information, or details of Approved Domestic Relations Orders. Medical records may be reviewed only when such approval is specifically indicated with the member's initials in the space below.*

### Important Information

- This authorization expires two years from the date of the notary signature.
- This form is unnecessary if a Durable Power of Attorney record is on file for the Member with ERFC.

### PART A. MEMBER INFORMATION

First Name	M.I.	Last Name	Social Security Number
Street Address		City	State      Zip Code
Home Telephone Number (Area Code-xxx-xxxx)		<b>Member Status</b> (Check <input checked="" type="checkbox"/> One) <input type="checkbox"/> Active Member <input type="checkbox"/> Retiree <input type="checkbox"/> Survivor Beneficiary to _____ <span style="display: block; text-align: right; font-size: small;">Deceased Member's Name</span>	

### PART B. AUTHORIZED INDIVIDUAL(S)

List the individual(s) with whom ERFC representatives may discuss general information about the Member's ERFC account and retirement benefits (within the limits cited herein).

Individual's Full Name	Relationship to Member	Last 4 Digits of SSN	Birthdate

**Check  and Initial below to confirm approval for one or both of the following authorizations:**

1. I hereby authorize ERFC representatives to discuss general information about my ERFC account and retirement benefits with the individual(s) listed above. ....  \_\_\_\_\_
2. I hereby authorize ERFC representatives to discuss information about my health or medical records with the individual(s) listed above as necessary and appropriate in relationship to my ERFC retirement plan. ....  \_\_\_\_\_

I understand this authorization expires two years from the date of my notarized signature below, or upon my written and notarized revocation earlier.

\_\_\_\_\_  
*Member's Signature* \_\_\_\_\_  
*Date*

TO BE COMPLETED BY NOTARY or by other Court Official authorized to take acknowledgements:

STATE OF: \_\_\_\_\_ City/County of: \_\_\_\_\_

On this \_\_\_\_\_ day of: \_\_\_\_\_, \_\_\_\_\_ the Member whose name is signed above personally appeared before me and acknowledged the foregoing signature to be his/hers, and having been duly sworn by me, made oath that the statements made in said instrument are true.

Notary Registration # \_\_\_\_\_

My commission expires: \_\_\_\_\_

\_\_\_\_\_  
*Notary Signature*