AUTHORIZATION TO RELEASE INFORMATION

I authorize any employer, insurance company, Medical Insurance Bureau, Workers' Compensation Board, Social Security Administration, physician, practitioner, hospital, or health care institution to release to the Municipal Employees Retirement System (MERS) any medical information, which may be required to establish the validity of this claim. I also authorize such company, person or organization to disclose any relevant claim information required for the review of this claim. I agree that a photocopy shall be as valid as the original.

I have read and understand all pages of this application and certify that, to the best of my knowledge, all information provided on this document is true and correct.

________________________________ ________________________

Signature Date

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