SAN FRANCISCO ELECTRICAL WORKERS HEALTH & WELFARE TRUST
NORTHERN CALIFORNIA ELECTRICAL WORKERS PENSION TRUST
720 Market Street, Suite 700
San Francisco, CA 94102
Telephone: (415) 263-3670

Authorization for Release of Information (including Protected Health Information)

Dear Participant:

Privacy regulations require the Trust Office to have authorization to discuss health care and eligibility information and retirement benefits over the phone. The enclosed Authorization Form allows you to permit the Trust Office to discuss health care and eligibility information and retirement benefits with the person(s) you designate on the form. If you so choose, the form also permits you to limit the release of health information and retirement benefits to yourself only.

Please review the instructions for completing the Authorization Form. Note the form contains three sections that must be completed and signed by each:

1) Member/Retiree
2) Spouse
3) Dependent(s) over the age of 18

Please **avoid any unnecessary inconvenience** by completing, signing, and returning the enclosed Authorization Form. You may revoke your authorization at any time.

Yours truly,

Plan Office
San Francisco Electrical Workers Health & Welfare Plan
Northern California Electrical Workers Pension Plan

revised 3/2026

Instructions for completing the - *Authorization for Release of Information*

The form has sections for Member/Retiree, Spouse, and Dependent(s) over the age of 18. Each section must be completed and signed by the appropriate individual. You may wish to copy the completed form for your records.

Member / Retiree Section

1. Fill in your name and social security number.

2. **If you are married** and you want to give your spouse authority to inquire about your health and retirement information, please enter his/her name and relationship (spouse) –or-
If you are not married or you want to give someone other than your spouse authority to inquire about your health and retirement information, please enter his/her name and relationship (mother, father, friend, etc.).

3. **If you are giving someone else authority, please sign and date form.**

OR

If you do not want to give anyone other than yourself authority to inquire about your health information and retirement benefits, place an "X" in the box where it says, "I do not want my Health Information and Retirement Benefits released to anyone but myself". **Please sign and date below the box**.

Spouse Section

1. Fill in your name and social security number.

2. **If you want to give your spouse (member/retiree)** authority to inquire about your health information and retirement benefits, please enter his/her name and relationship (spouse).
If you want to give someone other than your spouse authority to inquire about your health information and retirement benefits, please enter his/her name and relationship (mother, father, friend, etc.).

3. **If you are giving someone else authority, please sign and date form.**

OR

If you do not want to give anyone other than yourself authority to inquire about your health information and retirement benefits, place an "X" in the box where it says, "I do not want my Health Information and Retirement Benefits released to anyone but myself". **Please sign and date form below the box**.

Dependent(s) over the age of 18 Section

1. One form must be submitted for each dependent over the age of 18. Please make additional copies of the form if necessary.

2. Fill in your name and social security number.

3. **If you want to give your parents** authority to inquire about your health information, please enter their name and relationship (father, mother).
If you want to give someone other than your parents authority to inquire about your health information, please enter his/her name and relationship (friend, etc.).

4. **If you are giving someone else authority, please sign and date form.**

OR

If you do not want to give anyone other than yourself authority to inquire about your health information, place an "X" in the box where it says, "I do not want my Health Information released to anyone but myself". **Please sign and date form below the box**.

Authorization for Release of Information

The "Plan" as referred to on this form is the SAN FRANCISCO ELECTRICAL WORKERS HEALTH & WELFARE PLAN AND NORTHERN CALIFORNIA ELECTRICAL WORKERS PENSION PLAN

MEMBER/RETIREE SECTION

I, (Name)_____(SSN)_____authorize the Plan, and its business associates, to disclose claims, payment, eligibility and other related health information and retirement benefits about me to the following persons (select 1-2 persons if desired), at the request of such persons:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I have read and understand the section of this form entitled **Expiration, Revocation, and Redisclosure.**

Signature of Member_____**Date Signed** _____

-OR- ☐ I do not want my Health Information and Retirement Benefits released to anyone but myself.

Signature of Member_____**Date Signed** _____

SPOUSE SECTION

I, the **spouse** (Print Name) _____, (Spouse's Social Security #) _____of the above named member authorize the Plan to disclose claims, payment, eligibility, and other related health information and retirement benefits about me to the following persons (select 1-2 persons if desired) for the reasons and with the explanations listed above, at the request of such persons:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I have read and understand the section of this form entitled **Expiration, Revocation, and Redisclosure.**

Signature of Spouse_____**Date Signed** _____

-OR- ☐ I do not want my Health Information and Retirement Benefits released to anyone but myself.

Signature of Spouse_____**Date Signed** _____

DEPENDENT(S) OVER THE AGE OF 18 SECTION – copy and submit one form for each.

I, the **dependent** over the age of 18 (Print Name)_____,
(Social Security #) _____ authorize the Plan to disclose claims, payment, eligibility, and other related health information and retirement benefits about me to the following persons (select 1-2 persons if desired) for the reasons and with the explanations listed above, at the request of such persons:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I have read and understand the section of this form entitled **Expiration, Revocation, and Redisclosure.**

Signature of Dependent_____**Date Signed** _____

OR- ☐ I do not want my Health Information and Retirement Benefits released to anyone but myself.

Signature of Dependent_____**Date Signed** _____

Expiration, Revocation, and Redisclosure

I understand that this authorization will expire upon termination of my enrollment in the Plan, unless I revoke it sooner. I understand that I have the right to revoke it at any time, except to the extent that it has already been relied upon. I understand that if I decide to revoke this authorization, I must give notice of my decision in writing and send it to: SAN FRANCISCO ELECTRICAL WORKERS HEALTH & WELFARE PLAN AND NORTHERN CALIFORNIA ELECTRICAL WORKERS PENSION PLAN, 720 MARKET STREET, SUITE 700, SAN FRANCISCO, CA 94102.

I understand that authorization for release of information (including protected health information) that is disclosed pursuant to this authorization may be redisclosed by the persons I have identified above, and the Plan cannot prevent or protect such redisclosures, AND I understand that I am not required to sign this form to receive my health care benefits (enrollment, treatment or payment) and retirement benefits.

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