AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS
LOSS OF TIME & NON-WORK DISABILITY CREDITS

I, _____[Print Name], do hereby authorize the **CENTRAL LABORERS' WELFARE FUND** ("Welfare Fund") to release to the **CENTRAL LABORERS' PENSION FUND** ("Pension Fund") the following information:

> Any and all participant data, health information, and medical claims information, including, but not limited to, information related to alcohol, drug abuse, mental health treatment, and HIV/AIDS, that is maintained or received by the Welfare Fund and which is related to my disability and is needed by the Pension Fund to determine/verify my eligibility for Pension Credit and/or Vesting Service, as applicable, with the Pension Fund for periods I was unable to work in Covered Employment because of a disability.

This authorization for release of information covers all time periods relevant to the period of my disability and is effective when it is signed.

Right to Revoke. I understand that I may revoke this authorization at any time by giving written notice to the Welfare Fund. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. Notice of revocation must be sent to:

Central Laborers' Welfare Fund
c/o Christy Brake
P.O. Box 1267
Jacksonville, Illinois 62651
Fax 1-217-243-8619 or Email claims@central-laborers.com

Expiration of Authorization. If no prior notice of revocation is received, this authorization will expire automatically the later of (i) one year after the date indicated hereon, or (ii) after a final determination is made by the Pension Fund regarding my eligibility for Pension Credit/Vesting Service.

Potential for Re-Disclosure. I understand that the information used or disclosed may be subject to redisclosure by the person or facility receiving it, and may then no longer be protected by federal privacy regulations.

Benefits Not Conditioned on Form. I understand that I am not required to sign this form to receive health care benefits from the Welfare Fund.

Right to Copy. I understand that I have the right to inspect and copy the information to be disclosed.

Voluntary. I understand that I am under no obligation to sign this form. I acknowledge that I am voluntarily signing this form to release my health information to the Pension Fund.

_____
Participant's Signature

Dated:_____