aftra RETIREMENT FUND

AUTHORIZATION FORM

DIRECTIONS

1. The Performer (or Benefit Recipient in receipt of a benefit) may complete and sign this form assigning authority to receive information about their earnings and/or benefit.
2. This form is not required in the event you have given us a Power of Attorney (POA) which names the one person you wish to authorize.
3. Each signed copy of this form replaces all prior submissions. A single authorization will be retained on file.
4. Submission: Please complete and return this form by email, fax or mail to:

Email

authorizations@aftraretirement.org

Fax

Fax: (212) 499-4928

Mail

AFTRA Retirement Fund
Retirement Services Department
261 Madison Avenue, 7th Floor
New York, NY 10016

DEMOGRAPHIC INFORMATION

Legal Name

Last Name _____ First Name _____ Middle Name _____

Professional Name

Last Name _____ First Name _____ Middle Name _____

Date of Birth (mm/dd/yyyy) ____/____/_____ Social Security No. _____ AFTRA Retirement Fund No. _____

Contact Information

Home: (XXX) XXX-XXXX _____ Email Address _____

Cell: (XXX) XXX-XXXX _____

PERSON(S) AND ORGANIZATION(S) AUTHORIZED TO RECEIVE INFORMATION

This authorization will revoke any and all prior permissions that you may have given to anyone to receive information about your earnings and/or benefit information on your behalf.

The following Person(s) and/or Organization(s) are authorized to receive information about my earnings and/or benefit information on my behalf.

No.	Persons Authorized	Organization of Authorized Person (if applicable)	Relationship to the performer or benefit recipient
1			
2			
3			
4			
5			
6			

❑ I hereby give consent to the authorized person(s) or Organization(s) listed above to also update/change my demographic information.

Performer or Benefit Recipient's Signature _____ Date (mm/dd/yyyy) ____/____/_____