DMBA

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# EMPLOYER INFORMATION RELEASE AUTHORIZATION

## PARTICIPANT INFORMATION (REQUIRED)

To Deseret Mutual Benefit Administrators:

I, _____ grant
PARTICIPANT NAME

authorization for my employer _____ to access the checked
COMPANY NAME

information below about my Master Retirement Plan at DMBA. This authorization is valid for 12 months from the date this authorization is signed.

- ❑ Retirement benefit information
- ❑ Retirement application
- ❑ Retirement calculation
- ❑ Tax information
- ❑ Employment history from a previous employer
- ❑ Salary history from a previous employer

Name: _____

DMBA ID Number: _____

Signature: _____

Date: _____