

EMPLOYER INFORMATION RELEASE AUTHORIZATION

PARTICIPANT INFORMATION (REQUIRED)

To Deseret Mutual Benefit Administrators:

I, _____ (participant name) grant authorization for my employer _____ (company name) to access the checked 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: _____

Please return this completed form to retirementhelp@dmba.com. You may also mail it DMBA, Attention: Member Services, P.O. Box 45530, Salt Lake City, UT 84145-0530 or fax it to 801-578-5933. For questions, visit www.dmba.com or call us at 801-578-5600 or 800-777-3622.