RELEASE OF INFORMATION

FORM NO. 7

Employment

I hereby authorize the release of **any** employment information by my employer to the SGEU LTD Plan that is required for the purpose of administering my SGEU LTD Plan Long-Term Disability claim.

_____
Employer

_____
Member's Name

_____
Signature

_____
Date

This authorization shall remain valid for the duration of my claim for benefits unless previously revoked, in writing, by me or my representative signing this form. Any photocopy or electronic copy of this authorization shall be as valid as the original.