Nova Scotia Public Service
Long Term Disability Plan Trust Fund

AUTHORIZATION OF REPRESENTATIVE AND RELEASE OF FILE INFORMATION

I, _____, the undersigned, do hereby authorize _____, of _____, to be my representative in connection with my appeal of the denial/termination of long term disability benefits and authorize Manufacturers Life and the Office of the NSPS Long Term Disability Plan Trust Fund to release to my said representative any and all information contained in my file held by Manufacturers Life and the Office of the NSPS Long Term Disability Plan Trust Fund, including, but not limited to information in connection with my employment status and earnings, including income tax returns, and medical records, and for so doing, let this be your good and sufficient authority.

I hereby waive all claims against Manufacturers Life and the Office of the NSPS Long Term Disability Plan Trust Fund, its employees, and agents for all purposes whatsoever in connection with the disclosure of my file.

DATED at the Regional Municipality of _____, Province of Nova Scotia, this day of _____, 20__.

WITNESSED BY:)
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_____) _____
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