Consent Form

NSLIJ

Social Security Number: ___ — ___ — ____

BARCODE

First Name | M.I. | Last Name

Prior First Name | M.I. | Prior Last Name

If you changed your name because of marriage, divorce, etc., enter the name used when you were a medical resident.

Number and Street or P.O. Box Number

City, town or post office | State | Zip Code

Note: If foreign address, enter the information in the following order: city, province or state, and country. Follow the country's practice for entering the postal code. Please do not abbreviate the country name.

E-mail Address

___ — ___ — ____

Daytime Phone Number

For each year shown below, check "Yes" if you authorize North Shore-LIJ Health System to collect the refund on your behalf, or "No" if you do not authorize North Shore-LIJ Health System to collect the refund on your behalf, or you are not eligible for a refund. **Note:** You may only check a box for the year(s) in which you were in a training program.

1995	◯ Yes ◯ No	1996	◯ Yes ◯ No	1997	◯ Yes ◯ No
1998	◯ Yes ◯ No	1999	◯ Yes ◯ No	2000	◯ Yes ◯ No
2001	◯ Yes ◯ No	2002	◯ Yes ◯ No	2003	◯ Yes ◯ No
2004	◯ Yes ◯ No	1st Quarter of 2005	◯ Yes ◯ No	Remainder of 2005	◯ Yes ◯ No
2006	◯ Yes ◯ No	2007	◯ Yes ◯ No	2008	◯ Yes ◯ No
2009	◯ Yes ◯ No				

For each year I checked "Yes" above:

- I have not claimed and will not claim a refund or credit from the IRS for any overcollected FICA taxes from wages paid for services performed as a medical resident, or if I have, the claim was rejected.
- I did not receive a FICA tax refund or credit because of earning in excess of the social security wage base on my Federal income tax return (e.g., Form 1040).
- I understand that my Social Security earnings record will be corrected to reflect zero wages earned as resident for tax periods for which I received a refund. I understand that removing these wages could affect my eligibility to or the amount of future Social Security benefits.
- I give my consent to North Shore-LIJ Health System to file a Medical Resident FICA Refund Claim on my behalf for refunds of FICA taxes that North Shore-LIJ Health System withheld from my wages for services I performed as a medical resident.

SIGN HERE _____ Date:_____

Return your signed consent form postmarked no later than September 15, 2010 in the enclosed envelope to:

North Shore-LIJ Health System Claims Administrator
c/o Gilardi & Co. LLC
P.O. Box 1110
Corte Madera, CA 94976-1110

Keep a signed copy of the consent form for your records.