EXHIBIT 4

Social Security Administration

Consent for Release of Information

Form Approved
OMB No. 0960-0566

Instructions for Using this Form

Complete this form only if you want us to give information or records about you, a minor, or a legally incompetent adult, to an individual or group (for example, a doctor or an insurance company). If you are the natural or adoptive parent or legal guardian, acting on behalf of a minor child, you may complete this form to release only the minor's non-medical records. We may charge a fee for providing information unrelated to the administration of a program under the Social Security Act.

NOTE: Do not use this form to:

- Request the release of medical records on behalf of a minor child. Instead, visit your local Social Security office or call our toll-free number, 1-800-772-1213 (TTY-1-800-325-0778), or
- Request detailed information about your earnings or employment history. Instead, complete and mail form SSA-7050-F4. You can obtain form SSA-7050-F4 from your local Social Security office or online at www.ssa.gov/online/ssa-7050.pdf.

How to Complete this Form

We will not honor this form unless all required fields are completed. An asterisk (*) indicates a required field. Also, we will not honor blanket requests for "any and all records" or the "entire file." You must specify the information you are requesting and you must sign and date this form. We may charge a fee to release information for non-program purposes.

- Fill in your name, date of birth, and social security number or the name, date of birth, and social security number of the person to whom the requested information pertains.
- Fill in the name and address of the person or organization where you want us to send the requested information.
- Specify the reason you want us to release the information.
- Check the box next to the type(s) of information you want us to release including the date ranges, where applicable.
- For non-medical information, you, the parent or the legal guardian acting on behalf of a minor child or legally incompetent adult, must sign and date this form and provide a daytime phone number.
- If you are not the individual to whom the requested information pertains, state your relationship to that person. We may require proof of relationship.

PRIVACY ACT STATEMENT

Section 205(a) of the Social Security Act, as amended, authorizes us to collect the information requested on this form. We will use the information you provide to respond to your request for access to the records we maintain about you or to process your request to release your records to a third party. You do not have to provide the requested information. Your response is voluntary; however, we cannot honor your request to release information or records about you to another person or organization without your consent. We rarely use the information provided on this form for any purpose other than to respond to requests for SSA records information. However, the Privacy Act (5 U.S.C. § 552a(b)) permits us to disclose the information you provide on this form in accordance with approved routine uses, which include but are not limited to the following:

1.To enable an agency or third party to assist Social Security in establishing rights to Social Security benefits and or coverage;
2.To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level;
3.To comply with Federal laws requiring the disclosure of the information from our records; and,
4.To facilitate statistical research, audit, or investigative activities necessary to assure the integrity of SSA programs.

We may also use the information you provide when we match records by computer. Computer matching programs compare our records with those of other Federal, State, or local government agencies. We use information from these matching programs to establish or verify a person's eligibility for Federally-funded or administered benefit programs and for repayment of incorrect payments or overpayments under these programs. Additional information regarding this form, routine uses of information, and other Social Security programs is available on our Internet website, www.socialsecurity.gov, or at your local Social Security office.

PAPERWORK REDUCTION ACT STATEMENT

This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 3 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. You can find your local Social Security office through SSA's website at** www.socialsecurity.gov**. Offices are also listed under U.S. Government agencies in your telephone directory or you may call 1-800-772-1213 (TYY 1-800-325-0778).** You may send comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 21235-6401. ***Send only comments relating to our time estimate to this address, not the completed form.***

Social Security Administration

Consent for Release of Information

Form Approved
OMB No. 0960-0566

You must complete all required fields. We will not honor your request unless all required fields are completed. *(*Signifies a required field. **Please complete these fields in case we need to contact you about the consent form*).

TO: Social Security Administration

***My Full Name**	***My Date of Birth (MM/DD/YYYY)**	***My Social Security Number**

I authorize the Social Security Administration to release information or records about me to:

***NAME OF PERSON OR ORGANIZATION:** ***ADDRESS OF PERSON OR ORGANIZATION:**

***I want this information released because:** _____

We may charge a fee to release information for non-program purposes.

***Please release the following information selected from the list below:**

Check at least one box. We will not disclose records unless you include date ranges where applicable.

1. ☐ Verification of Social Security Number
2. ☐ Current monthly Social Security benefit amount
3. ☐ Current monthly Supplemental Security Income payment amount
4. ☐ My benefit or payment amounts from date _____ to date _____
5. ☐ My Medicare entitlement from date _____ to date _____
6. ☐ Medical records from my claims folder(s) from date _____ to date _____

   If you want us to release a minor child's medical records, do not use this form. Instead, contact your local Social Security office.
7. ☐ Complete medical records from my claims folder(s)
8. ☐ Other record(s) from my file (We will not honor a request for "any and all records" or "the entire file." You must specify other records; e.g., consultative exams, award/denial notices, benefit applications, appeals, questionnaires, doctor reports, determinations.)

I am the individual, to whom the requested information or record applies, or the parent or legal guardian of a minor, or the legal guardian of a legally incompetent adult. I declare under penalty of perjury (28 CFR § 16.41(d)(2004) that I have examined all the information on this form and it is true and correct to the best of my knowledge. I understand that anyone who knowingly or willfully seeking or obtaining access to records about another person under false pretenses is punishable by a fine of up to $5,000. I also understand that I must pay all applicable fees for requesting information for a non-program-related purpose.

***Signature:** _____ ***Date:** _____

****Address:** _____ ****Daytime Phone:** _____

Relationship (if not the subject of the record): _____ ****Daytime Phone:** _____

Witnesses must sign this form ONLY if the above signature is by mark (X). If signed by mark (X), two witnesses to the signing who know the signee must sign below and provide their full addresses. Please print the signee's name next to the mark (X) on the signature line above.

1.Signature of witness	2.Signature of witness
Address(Number and street,City,State, and Zip Code)	Address(Number and street,City,State, and Zip Code)

Attachment E

AUTHORIZATION FOR RELEASE OF WORKER'S COMPENSATION RECORDS

AUTHORIZED IN CONNECTION WITH
In re Paraquat Prods. Liab. Litig.
Southern District of Illinois
No. 3:21-md-3004-NJR

TO: Name _____
Address, City, State, Zip Code _____
_____

This will authorize you to furnish copies of any and all workers' compensation records of any sort, including, but not limited to, statements, applications, disclosures, correspondence, notes, settlements, agreements, contracts or other documents, concerning:

_____
Name of Claimant

Whose date of birth is _____ and whose social security number is _____.

I hereby authorize and request you to release the information to [ADDRESS] (the "Records Requester").

I intend that this authorization shall be continuing in nature. If information responsive to this authorization is created, learned, or discovered at any time in the future, either by you or another party, you must produce such information to the Records Requester at that time.

I acknowledge the right to revoke this Authorization to Release Employment Information by sending a written revocation notice to the above-referenced address, but that this revocation notice will not apply to information already released in response to this authorization and will not affect any actions taken in reliance on this authorization prior to the date my written revocation is received. I understand that the entity to which this authorization is directed may not condition treatment, payment, enrollment, or eligibility benefits on whether I sign the authorization. Any facsimile, copy, or photocopy of the authorization shall authorize you to release the records herein.

This Authorization to Release Employment Information shall remain effective throughout the duration of the above-referenced litigation and shall expire automatically at the close of the litigation.

_____ _____
Signature of claimant or personal representative Date

_____
Name of claimant and, if applicable, personal representative

_____
Description of Personal Representative's authority to sign for claimant
(attach documents that show authority)

Attachment F-1

AUTHORIZATION FOR RELEASE OF INSURANCE RECORDS

AUTHORIZED IN CONNECTION WITH
In re Paraquat Prods. Liab. Litig.
Southern District of Illinois
No. 3:21-md-3004-NJR

TO: Name _____
Address, City, State, Zip Code _____
_____

RE: Insured Name _____
Date of Birth _____ Social Security Number _____

I authorize you to furnish copies of any and all documents relating to any insurance policy or policies under which the above-referenced insured were covered and claimed benefits, including, but not limited to, claims made and payments received for such claims, as well as applications, forms, and correspondence or communications of any kind between you and the insured. I further authorize you to furnish copies of all medical, health, hospital, physicians, nursing, or allied health professional reports, records, notes, or invoices or bills in your possession related to the insured.

You are authorized to release the above records to: [INSERT ADDRESS] (the "Records Requester"), who has agreed to pay reasonable charges made by you to supply copies of such records.

This authorization does not authorize you to disclose anything other than documents and records to anyone.

I intend that this authorization shall be continuing in nature. If information responsive to this authorization is created, learned, or discovered at any time in the future, either by you or another party, you must produce such information to the Records Requester at that time. Any facsimile, copy, or photocopy of the authorization shall authorize you to release the records described herein.

This authorization shall remain effective throughout the duration of the litigation and shall expire automatically at the close of the litigation.

_____ _____
Signature of claimant or personal representative Date

_____
Name of claimant and, if applicable, personal representative

_____
Description of Personal Representative's authority to sign for claimant
(attach documents that show authority)

_____ _____
Signature of witness Date

Attachment F-2

AUTHORIZATION FOR RELEASE OF CROP INSURANCE RECORDS

AUTHORIZED IN CONNECTION WITH
In re Paraquat Prods. Liab. Litig.
Southern District of Illinois
No. 3:21-md-3004-NJR

Requester: _____
(Grower's Name)

Requester's Current Address: _____

_____

Date of Birth: _____

Social Security Number: _____

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct, and that I am the person named above, and I understand that any falsification of this statement is punishable under the provisions of 18 U.S.C. § 1001 by a fine of not more than $10,000.00 or by imprisonment of not more than five years or both, and that requesting or obtaining any record(s) under false pretenses is punishable under the provisions of 5 U.S.C. § 552(a)(i)(3) by a fine of not more than $5,000.00.

I request that the following records be released:

> Full and complete copies of all insurance policies, claims submitted, and any maps, plat books and descriptions of land or property related to any insurance coverage provided to [Farmer Name] and/or [Farming Entity Name], individually, jointly and/or by and through one or more partnerships, corporations or other entities, by the United States Department of Agriculture, Farm and Foreign Agriculture Services, Farm Service Agency, the Risk Management Agency and/or any private entity, from January 1, 1964 through the present, inclusive.

Pursuant to 7 U.S.C. § 1502(c)(2)(B), I further request, authorize and direct you to release any and all information relating to [Farmer Name] and/or [Farming Entity Name], including the foregoing records, to [ADDRESS].

I am voluntarily signing this consent, without promises being made to me, or any entity that I represent, nor under threat of duress or coercion.

NAME: _____

SIGNATURE: _____ (Signature of Grower/Requester)

DATE AND TIME: _____

Attachment G

AUTHORIZATION FOR RELEASE OF DISABILITY CLAIMS RECORDS

AUTHORIZED IN CONNECTION WITH
In re Paraquat Prods. Liab. Litig.
Southern District of Illinois
No. 3:21-md-3004-NJR

TO: Name _____
Address, City, State, Zip Code _____
_____

RE: Claimant Name_____
Date of Birth _____ Social Security Number_____

I authorize you to furnish copies of any and all records of disability claims of any sort, including, but not limited to, statements, applications, disclosures, correspondence, notes, settlements, agreements, contracts or other documents, concerning the above-referenced claimant.

You are authorized to release the above records to: [ADDRESS] (the "Records Requester"), who has agreed to pay reasonable charges made by you to supply copies of such records.

This authorization does not authorize you to disclose anything other than documents and records to anyone.

I intend that this authorization shall be continuing in nature. If information responsive to this authorization is created, learned, or discovered at any time in the future, either by you or another party, you must produce such information to the Records Requester at that time. Any facsimile, copy, or photocopy of the authorization shall authorize you to release the records described herein.

This authorization shall remain effective throughout the duration of the litigation and shall expire automatically at the close of the litigation.

_____ _____
Signature of claimant or personal representative Date

_____
Name of claimant and, if applicable, personal representative

_____
Description of Personal Representative's authority to sign for claimant
(attach documents that show authority)

_____ _____
Signature of witness Date

Attachment H

AUTHORIZATION FOR RELEASE OF FSA DOCUMENTS

AUTHORIZED IN CONNECTION WITH
In re Paraquat Prods. Liab. Litig.
Southern District of Illinois
No. 3:21-md-3004-NJR

RE: Requester: _____
Doing Business As (Grower's Name): _____
Requester's Current Address: _____
Date of Birth _____ Social Security Number_____

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct, and that I am the person named above, and I understand that any falsification of this statement is punishable under the provisions of 18 U.S.C. § 1001 by a fine of not more than $10,000.00 or by imprisonment of not more than five years or both, and that requesting or obtaining any record(s) under false pretenses is punishable under the provisions of 5 U.S.C. § 552a(i)(3) by a fine of not more than $5,000.00.

A. *Record Release:* I request that the following records be released:

1. All FSA records (including FSA 578, 1026A (if applicable), the USDA FSA Detailed Acreage History Report Form and aerial maps) and all records from the Risk Management Agency of the USDA relating to the above-named requester or any entity by or through which he or she may farm for the years **1964 through the present**.

Pursuant to 5 U.S.C. § 552a(b), I further request, authorize the release of any and all information relating to me, including the foregoing records, to: [INSERT ADDRESS] (the "Records Requester"), who has agreed to pay reasonable charges made by you to supply copies of such records.

I am voluntarily signing this consent, without promises being made to me, or any entity that I represent, nor under threat of duress or coercion.

I intend that this authorization shall be continuing in nature. If information responsive to this authorization is created, learned, or discovered at any time in the future, either by you or another party, you must produce such information to the Records Requester at that time. Any facsimile, copy, or photocopy of the authorization shall authorize you to release the records described herein.

This authorization shall remain effective throughout the duration of the litigation and shall expire automatically at the close of the litigation.

[Signature Page to Follow]

Signature of Grower/Requester | Date

Name of Grower/Requester

Description of Requester's authority to sign for Grower
(attach documents that show authority)

Signature of witness | Date