

**AUTHORIZATION FOR THE SOCIAL SECURITY ADMINISTRATION TO OBTAIN ACCOUNT RECORDS FROM A FINANCIAL INSTITUTION AND REQUEST FOR RECORDS**

CUSTOMER'S NAME	SOCIAL SECURITY NUMBER
NAME AND ADDRESS OF FINANCIAL INSTITUTION	APPLICANT/RECIPIENT IF OTHER THAN CUSTOMER
	SOCIAL SECURITY NUMBER

ACCOUNT NUMBER(S)

JOINT ACCOUNT,  DIRECT DEPOSIT

JOINT ACCOUNT,  DIRECT DEPOSIT

JOINT ACCOUNT,  DIRECT DEPOSIT

The Social Security Administration will request records to determine initial or continuing eligibility and the accuracy of the payment for Supplemental Security Income benefits. I understand that any information obtained will be kept confidential and that:

1. I have the right to revoke this authorization at any time before any records are disclosed; and
2. If I am an applicant or recipient, failing to provide or revoking my authorization will result in a denial or suspension of benefits; and
3. If I am a person whose income and resources the Social Security Administration considers as being available to an applicant or recipient, failing to provide or revoking my authorization may result in a denial of benefits for the applicant or a suspension of benefits for the recipient; and
4. The Social Security Administration may request all records about me from any financial institution, whether or not listed above; and
5. I have the right to obtain a copy of the record which the financial institution keeps concerning the instances when it has disclosed records to a Government authority unless the records were disclosed because of a court order; and
6. This authorization is not required as a condition of doing business with the financial institution named above.

I authorize any custodian of records at any financial institution to disclose to the Social Security Administration any records about my financial business or that of the person named above whom I legally represent or whose benefits I manage .

CUSTOMER'S AUTHORIZATION	MAILING ADDRESS	DATE
LEGAL REPRESENTATIVE'S AUTHORIZATION	LEGAL REPRESENTATIVE'S MAILING ADDRESS	DATE

Your authorization does not ordinarily have to be witnessed. However, if you have signed by mark (X), two witnesses to the signing who know you must sign below giving their full addresses .

1. SIGNATURE OF WITNESS	2. SIGNATURE OF WITNESS
ADDRESS (Number, Street, City, State, Zip Code)	ADDRESS (Number, Street, City, State, Zip Code)

I CERTIFY that the applicable provisions of the Right to Financial Privacy Act of 1978 (12U.S.C. 3401-3422) have been complied with in this request. Pursuant to the Right to Financial Privacy Act of 1978, good faith reliance upon this certification relieves your institution and its employees and agents of any possible liability to the customer in connection with the disclosure of these financial records.

AUTHORIZATION OF SOCIAL SECURITY ADMINISTRATION REPRESENTATIVE	TELEPHONE NO (INCLUDE AREA CODE)	DATE
--	----------------------------------	------

## REQUEST FOR RECORDS

This request is authorized by section 1631(e)(1)(B) of the Social Security Act, as amended. While you are not required to respond, your cooperation will help us determine the eligibility of the applicant or recipient named above for Supplemental Security Income benefits. The customer's authorization for release of the information contained in your records appears on the attachment to this form.

### INSTRUCTIONS FOR COMPLETION

- Refer to page one for information concerning the accounts to be verified. If the customer owns other accounts that are not listed, please provide information on those accounts for the time frame requested.
- We need account information even if the account has been closed or the account number has changed.
- Spaces are available for up to three accounts. If there are more than three accounts, please provide information on a separate sheet of paper.
- Please include at the end of this form the name of the financial institution representative providing account information.
- When necessary, we will provide a postage free return envelope.
- If no accounts are located, check the box below where indicated.

	ACCOUNT 1	ACCOUNT 2	ACCOUNT 3
TYPE OF ACCOUNT <sup>1</sup>			
ACCOUNT NUMBER			
NAME(S) ON AND EXACT ACCOUNT DESIGNATION			

<sup>1</sup>Checking, Savings, Time/Certificate of Deposit, Keogh, IRA, UGMA/UTMA, Escrow, Etc.

- **No accounts were located for this customer.**

- Please provide information for the period \_\_\_\_\_ through \_\_\_\_\_ for the account number(s) listed above and any others held (either individually or jointly) by the above named customer.
- For all accounts, provide opening balances as of the first day of the month for each account.
- Unless this box is checked, do not provide interest paid or credited during each month.

Month/Year	ACCOUNT 1		ACCOUNT 2		ACCOUNT 3	
	Balance	Interest Paid	Balance	Interest Paid	Balance	Interest Paid

