Form Approved
OMB No. 0960-0293

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) (INDIVIDUAL OR JOINT)

______________________, ______________________, ______________________

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

1. This authorization is valid for up to 3 months from the date of my signature; and
2. I have the right to revoke this authorization at any time before any records are disclosed; and
3. The Social Security Administration is requesting all records appearing on the attachment to this authorization, whether or not listed above; and
4. I have a right to 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
5. This authorization is not required as a condition of doing business with the financial institution named above; and
6. As a customer, my authorization is voluntary; however, if I am an applicant or recipient, failure to provide my signature below may result in a suspension or loss of benefits.

I authorize any custodian of records at the financial institution named above 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 benefit I manage.

CUSTOMER'S SIGNATURE	MAILING ADDRESS	DATE
LEGAL REPRESENTATIVE'S OR REPRESENTATIVE PAYEE'S SIGNATURE	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 (12 U.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.

SIGNATURE OF SOCIAL SECURITY ADMINISTRATION REPRESENTATIVE	TELEPHONE NO. (include area code)	DATE

ADDRESS

INFORMATION FOR THE FINANCIAL INSTITUTION

WHY THIS INFORMATION IS NEEDED

To ensure that supplemental security income (SSI) payments are made only to eligible persons, it is sometimes necessary to verify allegations about financial institution accounts. Experience has shown that the verification you provide is directly responsible for reducing the number of incorrect payments and results in savings to the taxpayer.

Most of the time we use the customer's records, but sometimes we check with you to:

- Discover other accounts which may not have been reported to us. SSA studies confirm that unreported accounts are discovered most often where a customer acknowledged having an account.
- Find out the exact balance of all accounts as of the first day of the month. Since we periodically review an individual's circumstances to ensure eligibility for SSI, we sometimes ask for balances covering more than a year.
- Ask about interest payments because SSI is a needs based program and we must know about all available income to determine if it affects eligibility or payment.

IMPORTANT REMINDER ITEMS

Page 1: Make sure that the customer(s) (or representative) and the SSA representative have signed and dated the form. If a signature is missing, call the SSA office shown.

Page 3: Part I--Read this to find out **which** accounts need to be verified. **If the customer owns other accounts which are not shown in part I. please also provide the information needed about these accounts.**

Part II--Read this to find out **what** information is needed to verify those accounts.

Page 4: Use this page to furnish the verifying information. **Note: The information is needed even if the account has been closed.** Please show the following formation in:

Part A: The type of account, account number, and designation exactly as shown on the account.

Part B: 1. The opening balance(s) as of the first day of the month(s) listed. If your records show only closing balances, enter the closing balance for the last day of the previous month.

2. The amount of interest paid or credited the account(s) in each month listed.

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 6 minutes to read the instructions, gather the facts, and answer the questions. **SEND THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. The office is listed under U. S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213.** *You may send comments on our time estimate above to: SSA, 1338 Annex Building, Baltimore, MD 21235-6401.* ***Send only comments relating to our time estimate to this address, not the completed form.***

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it.

Explanations about these and other reasons why information you provide us may be used or given out are available in Social Security offices. If you want to learn more about this, contact any Social Security office.

PLEASE BE SURE TO SIGN AND DATE THE FORM AND RETURN IT IN THE ENVELOPE PROVIDED.

ADDITIONAL INFORMATION/REMARKS FROM SSA

REQUEST FOR RECORDS

PART I - FOR COMPLETION BY THE SOCIAL SECURITY REPRESENTATIVE

Customer's Name	Customer's Social Security Number
Financial Institution Name and Address	Applicant/Recipient If Not Customer
	Social Security Number

Account Number(s) (Individual or Joint)

______________________ , ______________________ , ______________________

The financial institution is requested to provide information In Part II for the period __________ through __________ for the account number(s) listed above, whether "active" or "inactive/closed," and any others, such as certificates of deposit, etc., held (individually or jointly) by the above named customer or applicant/recipient.

PART II - FOR COMPLETION BY THE FINANCIAL INSTITUTION REPRESENTATIVE

This request is authorized by sections 1631(e)(1)(B), 1102, and 403j 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 below 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 Part I above for information about the accounts to be verified
- Spaces are available for up to three accounts. If there are more than three accounts, provide information in the "Remarks" section or attach a separate sheet of paper. **Note: copies of bank records, including computer printouts, are acceptable in lieu of manual entries on the form.**
- **IN ALL CASES**, A FINANCIAL INSTITUTION REPRESENTATIVE'S SIGNATURE MUST APPEAR IN THE SPACES PROVIDED AT THE END OF THIS FORM. A postage free return envelope is enclosed for your convenience.
- If no accounts are located, check box in section A, page 4, and sign where indicated.

REMARKS

Customer's Name:

Social Security Number:

A.	ACCOUNT 1	ACCOUNT 2	ACCOUNT 3
Type of Account*			
Account Number			
Name(s) On and Exact Account Designation			

☐ No accounts were located for this customer.

*Checking, Savings, Time/Certificate of Deposit, IRA, Keogh, Trust, Etc.

B. Provide the information in the box(es) checked for the months indicated. Copies of account records may be submitted in lieu of entering data below.

☐ 1. Opening Balance(s) As Of the First Day of the Month for Each Account (or Balance on the Close of Business of the Last Day of the Previous Month).

☐ 2. The Amount of Interest Paid or Credited During Each Month.

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

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge.

Signature of Financial Institution Representative	Phone Number ( )
	Date