SOCIAL SECURITY ADMINISTRATION

Form Approved
OMB No. 0960-xxxx

STATEMENT OF CLAIMANT OR OTHER PERSON-MEDICAL RESIDENT FICA REFUND CLAIMS

WAGE EARNER	SOCIAL SECURITY NUMBER

NAME OF PERSON MAKING STATEMENT *(If other than above wage earner)*

RELATIONSHIP TO WAGE EARNER

Understanding that this statement is for the use of the Social Security Administration, I hereby certify that-

I/the medical resident signed a consent form to obtain a refund of FICA taxes paid to the Internal Revenue Service (IRS) for the period of time that I/the medical resident worked as a medical resident for _____, EIN _____. I understand that the Social Security Administration (SSA) wants to confirm with me that I still want the refund because the IRS will begin to process Medical Resident FICA Refund Claims soon and I am currently entitled to Social Security benefits.

I understand that if I accept this FICA refund, my Social Security benefits will be lowered or terminated because the Social Security Administration will remove earnings from my/the medical resident's earnings record.

Do You Want to Accept the FICA Refund?

___ No	I do not want the FICA refund. I understand that SSA will not remove any wages from my/the medical resident's earnings record.
___ Yes	I want the FICA refund. I am aware that by accepting the FICA refund, SSA will lower or terminate my Social Security benefits. I also understand that I may have to repay benefits to SSA.

SSA has my permission to share this information with the IRS and my employer.

I know that anyone who makes or causes to be made a false statement or representation of material fact in an application or for use in determining a right to payment under the Social Security Act commits a crime punishable under Federal law and/or State law. I affirm that all information I have given in this document is true.

SIGNATURE OF PERSON MAKING STATEMENT

Signature *(First name, middle name, last name) (Write in ink)*	Date *(Month,day,year)*
SIGN HERE	Telephone number *(Include Area Code)*

Mailing Address *(Number and street, Apt. No., P.O. Box, Rural Route)*

City and State	*ZIP Code*

Witnesses are required ONLY if this statement has been signed by an X above. If signed by an X, two witnesses to the signing who know the individual must sign below, giving their full addresses.

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)*

Privacy Act Statement

Collection and Use of Personal Information

Section 205(a) of the Social Security Act, as amended, authorizes us to collect this information. The information you provide will be used to confirm that you are accepting a refund of your Federal Insurance Contribution Act (FICA) taxes, and to acknowledge that your Social Security benefits will be affected.

The information you furnish on this form is voluntary. However, failure to provide the requested information may delay the processing of your refund.

We generally use the information you supply to confirm your decision to accept a refund of your FICA taxes and that you are aware of how your benefits are affected. However, we may use it for the administration and integrity of Social Security programs. We may also disclose information to another person or to another agency in accordance with approved routine uses, which include but are not limited to the following:

1. To enable a third party or an agency to assist Social Security in establishing rights to Social Security benefits and/or coverage;

2. To comply with Federal laws requiring the release of information from Social Security records (e.g., to the Government Accountability Office and Department of Veterans' Affairs);

3. To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level; and

4. To facilitate statistical research, audit or investigative activities necessary to assure the integrity of Social Security programs.

We may also use the information you provide in computer matching programs. Matching programs compare our records with records kept by other Federal, state, or local government agencies. Information from these matching programs can be used to establish or verify a person's eligibility for Federally funded or administered benefit programs and for repayment of payments or delinquent debts under these programs.

Explanations about these and other reasons why information you provide us may be used or given out are available in Systems of Records Notice 60-0059 (Earnings Recording and Self-Employment Income System). The Notice, additional information about this form, and any other information regarding our systems and programs, are available on-line at 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 XX minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING 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 (TTY 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.***