Form Approved
OMB No. 0960-0098

REQUEST FOR WORKERS' COMPENSATION/PUBLIC DISABILITY BENEFIT INFORMATION

PRIVACY ACT/PAPERWORK ACT NOTICE: Your response to this request is voluntary; however, failure to provide all or part of the requested information could prevent an accurate and timely decision on this claim and could affect the claimant's Social Security benefits. The Social Security Administration uses the information you furnish to determine the effect of the claimant's workers' compensation or public disability benefit on his or her Social Security disability insurance benefits, as provided in section 224 of the Social Security Act (42 U.S.C. 424)The information on this form may be disclosed by the Social Security Administration to another person or agency for the following purposes: (1) to assist the Social Security Administration in establishing the right of a beneficiary to Social Security benefits; (2) to facilitate statistical research and audit activities necessary to assure the integrity and improvement of the Social Security programs; and (3) to comply with laws requiring the exchange of information between the Social Security Administration and another agency.

TO:	REQUESTING OFFICE
	SIGNATURE OF SSA OFFICIAL
	TITLE
	DATE

COMPUTER MATCHING STATEMENT: 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 office. If you want to learn more about this, contact any Social Security Office.

I. IDENTIFICATION OF WORKER (To be completed by the Social Security Administration)

NAME OF WORKER	2. SOCIAL SECURITY
3. ADDRESS OF WORKER	4. EMPLOYER'S NAME AND ADDRESS
5. CLAIM NUMBER(S)	6. DATE IF INJURY OR ONSET OF DISEASE (if applicable)
I request and authorize release of information concerning my claim for workers' compensation or other public disability benefits to the Social Security Administration →	Signature (If required by State or other entity)

INSTRUCTIONS FOR COMPLETION OF FORM

The Social Security Administration is required by law to reduce Social Security disability benefits when the worker is also receiving worker's compensation, black lung benefits, or other public disability benefits. If your office has no record of a claim by the worker named above, or if the worker filed a claim but was denied, please check the appropriate block below, sign on the reverse, and return this form to the Social Security Administration.

☐ No Record of Claim ☐ Claim Denied - No Appeal ☐ Claim Denied - Appeal Pending

If the claim by the named worker is pending, indicate when a decision is expected. _____

IF THE WORKER HAS EVER RECEIVED PERIODIC PAYMENTS OR A LUMP SUM AWARD, COMPLETE THE REVERSE SIDE OF THIS FORM. IT IS IMPORTANT THAT ALL BENEFIT INFORMATION IS COMPLETED AS ACCURATELY AS POSSIBLE BECAUSE THE WORKER'S SOCIAL SECURITY BENEFITS MAY BE REDUCED BASED ON THE INFORMATION PROVIDED.

RETURN TO:

SOCIAL SECURITY ADMINISTRATION

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 15 minutes to read the instructions, gather the facts, and answer the questions. **SEND THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. To find the nearest office, call 1-800-772-1213.** *Send only comments on our time estimate above to: SSA, 1338 Annex Building, Baltimore, MD 21235-0001.*

II. INFORMATION REQUESTED (To be completed by addressee)

NOTE: A copy of the compensation decision, payment record, court order, award letter, etc. which clearly shows the payment data requested below may be submitted in lieu of completing this form.

7. a. Periodic workers' compensation or public disability payments to worker

DATE PAYMENT EFFECTIVE	DATE ENDED	WEEKLY AMOUNT	ATTORNEY FEES AND OTHER EXPENSES INCLUDED IN WEEKLY AMOUNT	ENTER TYPE OF PAYMENTS			
				TEMPORARY		PERMANENT	
				PARTIAL	TOTAL	PARTIAL	TOTAL

b. Most recent payment stopped because (Check appropriate block).

☐ Lump-Sum Settlement Pending- Decision Expected By _____

☐ Permanent Rating Pending - Decision Expected By _____

☐ Award Under Appeal - Decision Expected By _____

☐ Other (Explain in "Remarks").

8. a. Lump sum payment to worker

DATE OF SETTLEMENT(S)	GROSS AMOUNT(S)	RATE(S) PER WEEK	NUMBER OF WEEKS	BEGINNING DATE

b. The following expenses were deducted from the gross amount:

1. Present and past medical expenses → **$**
2. Future medical expenses → **$**
3. Attorney fees → **$**
4. Other related expenses (Explain in "Remarks".) → **$**

9. Are the benefits reduced (or will be reduced) because of the worker's receipt of Social Security Benefits? → ☐ Yes ☐ No

10. If the payments are **not** workers' compensation, (for example, disability retirement) **and** the worker was a **State** or **local** government employee, were Social Security taxes (that is, FICA taxes) paid on the worker's earnings? (If "No", go on to item 12.) ☐ Yes ☐ No

What were the total number of years of service (FICA and non-FICA)? →	TOTAL YEARS/MONTHS	How many years was the worker engaged in employment "covered " by Social Security? →	YEARS/MONTHS

11. If the disability payments are **not** workers' compensation, but are being made under a **Federal** law or plan, was any of the worker's service covered under Social Security (i.e., FICA taxes were paid), including military service **after 1956**? ☐ Yes ☐ No (If "No", go on to item 12.)

What were the total number of years of service (FICA and non-FICA)? →	TOTAL YEARS/MONTH	How many years was the worker engaged in Federal employment covered by Social Security, including military service **after 1956**, but not military service before 1957? (OPM - Include deposit service.) →	YEARS/MONTHS

12. Remarks _____

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. I understand that anyone who knowingly gives a false or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime and may be sent to prison, or may face other penalties, or both.

13. SIGNATURE OF PERSON COMPLETING THE FORM	TELEPHONE NO. (include area code)
TITLE	DATE