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

NAME AND ADDRESS OF FINANCIAL INSTITUTION	CUSTOMER'S NAME	CUSTOMER'S NAME		
	SOCIAL SECURITY NUMBER	_		
ACCOUNT NUMBER(S) (INDIVIDUAL OR JOINT)				
A request for records will be made by the Social Security Adm subsidy amount for Medicare Part D-Extra Help with Medicare		g eligibility and the accuracy of the		
 This authorization is valid for up to 3 months from the I have the right to revoke this authorization at any tim The Social Security Administration is requesting all reabove; and 	ne before any records are disclosed; and ecords appearing on the back of this autho			
 4. I have the right to obtain a copy of the record which t records to a Government authority unless the records 5. This authorization is not required as a condition of do 	s were disclosed because of a court order; ping business with the financial institution n	and named above; and		
As a customer, my authorization is voluntary; however of eligibility.	er, failure to provide my signature below m	ay result in a suspension or loss		
I authorize any custodian of records at the financial institution about my financial business or that of the person named abov				
CUSTOMER'S SIGNATURE	MAILING ADDRESS	DATE		
LEGAL REPRESENTATIVE'S OR REPRESENTIVE PAYEE'S SIGNATURE	REPRESENTATIVE'S MAILING ADDRESS	DATE		
Your authorization does not ordinarily have to be witnessed. know you must sign below giving their full addresses.	However, if you have signed by mark (X), t	two witnesses to the signing who		
SIGNATURE OF WITNESS	2. SIGNATURE OF WITNESS			
ADDRESS (Number, Street, City, State, Zip Code)	ADDRESS (Number, Street, City, State, Zip	p Code)		
I CERTIFY that the applicable provisions of the Right to Finan this request. Pursuant to the Right to Financial Privacy Act of				
its employees and agents of any possible liability to the custom	mer in connection with the disclosure of the			
SIGNATURE OF SOCIAL SECURITY ADMINISTRATION REPRESENTATIVE	TELEPHONE NO (INCLUDE AREA CODE)	DATE		
ADDRESS				

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Form SSA-4640

REQUEST FOR RECORDS

The customer's authorization for release of the information contained in your records appears on the front of this form.

INSTRUCTIONS FOR COMPLETION

- Refer to the front of this form for information concerning the accounts to be verified.
- Spaces are available for up to four accounts. If there are more than four accounts, please provide information on 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 SPACE PROVIDED AT THE END OF THIS FORM. A postage free return envelope is enclosed for your convenience.
- If no accounts are located, check box below and sign where indicated.

	ACCOUNT 1	ACCOUNT 2	ACCOUNT 3	ACCOUNT 4
TYPE OF ACCOUNT ¹				
ACCOUNT NUMBER				
NAME(S) ON AND EXACT ACCOUNT DESIGNATION				
BALANCE AS OF (Date)				
BALANCE AS OF (Date)				
¹ Checking, Savi	ings, Time or Certificate of Depo	osit, Keogh, IRA, Trust, Mut	ual Funds, Stocks, Bond	ls, Christmas or Vacation Club, etc.
☐ No ac	counts were located for this	customer.		
	nder penalty of perjury that ring statements or forms, a			
Signature of F	Financial Institution Representat	ive		Phone Number () Date
				,

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 a maximum of 1 minute for Medicare Part D subsidy applicants and 4 minutes for financial institutions to read the instructions, gather the facts, and answer the questions. 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.

See below for revised Paperwork Reduction Act Statement.

Form SSA-4640 2

Privacy Act Statement

Collection and Use of Personal Information

Section 1860D-14 of the Social Security Act, as amended, authorizes us to collect this information. The information you provide will be used to obtain financial information in regards to determining initial or continuing eligibility, as well as the accuracy of the subsidy amount for Medicare Part D benefits.

The information you furnish on this form is voluntary. However, failure to provide the requested information could result in a suspension or loss of eligibility.

We rarely use the information you supply for a See below for Medicare Part D. However, we may use it for programs. We may also disclose information to another agency in accordance with approved routine uses, which include but the second of the second of

- 1. To enable a third party or an agency to assist Social Security in establishing rights to Medicare 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 Medicare 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 60-0321 (Medicare Database File). The Notice, additional information about this form, and any other information regarding our systems and programs, are available on-line at www.ssa.gov or at your local Social Security office.

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SSA will insert the following revised PRA Statement into the form at its next scheduled reprinting:

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the <u>Paperwork Reduction Act of 1995</u>. 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 1 to 4 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 <u>www.socialsecurity.gov</u>. Offices are also 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 <u>only</u> comments relating to our time estimate to this address, not the completed form.**

SSA will insert the following revised Privacy Act Statement into the form at its next scheduled reprinting:

Privacy Act Statement

Collection and Use of Personal Information

Section 1860D-14 of the Social Security Act, as amended, authorizes us to collect the information on this form. We will use the information you provide to obtain financial information to determine initial or continuing eligibility, and the accuracy of the subsidy amount for Medicare Part D benefits. Your response is voluntary. However, failing to provide us with all or part of the information could affect our ability to determine your eligibility Medicare Part D benefits.

We rarely use the information you provide for any purpose other than for determining eligibility for Medicare Part D. In accordance with 5 U.S.C. § 552a(b) of the Privacy Act, however, we may disclose the information provided on this form 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 recovering program debt;
- 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 and improvement of Social Security programs.

We may also use the information you provide in computer matching programs. Computer matching programs compare our records with those of other Federal, State, or local government agencies. We can 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 payments or delinquent debts under these programs.

A complete list of routine uses for this information is available in our System of Records Notice entitled, Medicare Database File (MDF) 60-0321. This notice, additional information regarding this form, and information regarding our programs and systems, are available on-line at http://www.socialsecurity.gov or at your local Social Security office.