Social Security Administration

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
	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 the subsidy amount for Medicare Part D-Extra Help with Medicare Prescription Drug Costs:

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 back of this authorization, whether or not listed above; and
4. 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
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, failure to provide my signature below may result in a suspension or loss of eligibility.

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 REPRESENTIVE 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 (12U.S.C. 3401-3422) have been complied within 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		

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, Savings, Time or Certificate of Deposit, Keogh, IRA, Trust, Mutual Funds, Stocks, Bonds, Christmas or Vacation Club, etc.

☐ No accounts were located for this customer.

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

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.***

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 give us when we match records by 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. The law allows us to do this even if you do not agree to it.

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.