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

ACCOUNT NUMBER(S)

☐ JOINT ACCOUNT, ☐ DIRECT DEPOSIT ☐ JOINT ACCOUNT, ☐ DIRECT DEPOSIT ☐ JOINT ACCOUNT, ☐ DIRECT DEPOSIT

_____ , _____ , _____

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

1. I have the right to revoke this authorization at any time before any records are disclosed; and
2. If I am an applicant or recipient, failing to provide or revoking my authorization will result in a denial or suspension of benefits; and
3. If I am a person whose income and resources the Social Security Administration considers as being available to an applicant or recipient, failing to provide or revoking my authorization may result in a denial of benefits for the applicant or a suspension of benefits for the recipient; and
4. The Social Security Administration may request all records about me from any financial institution, whether or not listed above; and
5. 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
6. This authorization is not required as a condition of doing business with the financial institution named above.

I authorize any custodian of records at this financial institution 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 benefits I manage.

CUSTOMER'S SIGNATURE/AUTHORIZATION	MAILING ADDRESS	DATE
LEGAL REPRESENTATIVE'S SIGNATURE /AUTHORIZATION	LEGAL 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 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.

AUTHORIZATION OF SOCIAL SECURITY ADMINISTRATION REPRESENTATIVE	TELEPHONE NO (INCLUDE AREA CODE)	DATE

ADDRESS

Customer's Name:	Social Security Number:

REQUEST FOR RECORDS

This request is authorized by section 1631(e)(1)(B) 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 above for Supplemental Security Income benefits. The customer's authorization for release of the information contained in your records appears on page one of this form.

Please provide information for the period _____ through _____ for the account number(s) listed above and any others held (either individually or jointly) by the above named customer.

SSA REMARKS

FOR COMPLETION BY THE FINANCIAL INSTITUTION REPRESENTATIVE

INSTRUCTIONS FOR COMPLETION

- Refer to page one for information concerning the accounts to be verified. If the customer owns other accounts that are not listed, please provide information on those accounts for the time frame requested.
- We need account information even if the account has been closed or the account number has changed.
- Spaces are available for up to three accounts. If there are more than three accounts, please provide information on a separate sheet of paper.
- Please include at the end of this form the name of the financial institution representative providing account information.
- Please return this form and all supporting materials to the Social Security Administration in the postage free return envelope provided.
- If no accounts are located, check the box below where indicated.

	ACCOUNT 1	ACCOUNT 2	ACCOUNT 3
TYPE OF ACCOUNT 1			
ACCOUNT NUMBER			
NAME(S) ON AND EXACT ACCOUNT DESIGNATION			

1 Checking, Savings, Time/Certificate of Deposit, Keogh, IRA, UGMA/UTMA, Escrow, Etc.

☐ **No accounts were located for this customer.**

- Copies of account records may be submitted in lieu of entering data below.
- For all accounts, provide opening balances as of the first day of the month for each account, for each month listed in the period.

☐ **Unless this box is checked, do not provide interest paid or credited during each month.**

Customer's Name:	Social Security Number:

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

Name of Financial Institution Representative	Phone Number
	Date

REMARKS

Privacy Act Statement
Collection and Use of Personal Information

Section 1631(e)(1)(B) of the Social Security Act, as amended, authorizes us to collect this information. The information you provide will be used to determine the eligibility of the applicant or recipient named above for Supplemental Security Income benefits.

The information you furnish on this form is voluntary. However, failure to provide the requested information may prevent an accurate and timely decision on eligibility, or could result in the loss of benefits.

We rarely use the information you supply for any purpose other than for determining eligibility for Supplemental Security Income benefits. 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, and 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.

Additional information regarding this form, routine uses of information, and our programs and systems, is 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 6 minutes 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***.