

Instructions for Claimant - Please list all doctors and health care providers who were involved in diagnosing and treating your injury, as well as any other entities (e.g., insurance companies, workers' compensation programs, pension programs) that may have medical information in Section 1. Then, please print your name and address and sign in the block in Section 2. Once you have completed and signed this authorization, please make a copy of your signed form and maintain it with your personal records.

When you sign this document, you give permission to your doctors, health care providers or other entities listed below to disclose your health information to the September 11th Victim Compensation Fund (VCF), the United States Department of Justice (DOJ), and the World Trade Center (WTC) Health Program administered by the National Institute for Occupational Safety and Health (NIOSH)¹ for purposes of evaluating your claim for compensation to the VCF. By signing this document, you also give permission to the VCF to disclose your health information to the WTC Health Program and to the WTC Health Program to disclose your health information to the VCF for the purpose of evaluating your claim for compensation under the VCF.

Please note that you may revoke this Authorization at any time, except to the extent that the VCF, WTC Health Program, or the providers listed below have already acted based on this Authorization. To revoke this authorization, you must write to the providers or entities listed below and to the VCF at the address at the bottom of page 3 of this form². This authorization is valid for six (6) years from the date signed or upon your written termination, whichever is sooner.

Your doctors and medical providers may not condition treatment, payment, enrollment or eligibility for benefits on whether you sign this Authorization. However, the VCF may not be able to evaluate your claim if you do not authorize the release of your medical records. Your decision to sign or not sign this authorization also has no impact on your eligibility for enrollment, monitoring, treatment, or other WTC Health Program benefits.

Your providers and certain other entities are required by the Privacy Rule under HIPAA to protect your health information. When they provide the information to the VCF it will not be protected by this same Privacy Rule. However, the VCF and DOJ will continue to protect the confidentiality of your medical records to the extent they are permitted to do so under another Federal law, the Privacy Act³ The VCF will not disclose your identifiable health information that it receives under this Authorization without your written consent except where authorized to do so by law.

Information to be disclosed by your health care providers (or other entities listed below) to the Victim Compensation Fund includes, but is not limited to, application or enrollment information, eligibility information, claims records, claim status, pension records and files, entire patient medical records, patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to your doctors and medical care providers by other health care providers. Your health care

¹ For the purposes of this document, all references to the WTC Health Program also include NIOSH to the extent it administers the WTC Health Program.

² If you wish to revoke this authorization because you do not want the VCF and WTC Health Program to exchange your health information for purposes of evaluating your claim for compensation under the VCF, then you only need to write to the VCF.

³ The WTC Health Program will protect your health information pursuant to HIPAA and/or any other relevant laws and regulations.





providers and/or the VCF may also disclose this information to the WTC Health Program for the purpose of evaluating your claim for benefits under the VCF. In addition, the WTC Health Program may disclose information to the VCF for purposes of evaluating your VCF claim. This information includes, but is not limited to, whether you are a member of the WTC Health Program, and if so, where you receive your WTC Health Program health care benefits; whether you have been certified for treatment under the WTC Health Program; the number of and specific conditions for which you have been certified for treatment under the WTC Health Program; and information relating to payment of claims for treatment and pharmaceuticals received under the WTC Health Program.

Disclosure requested will include otherwise confidential information. If records include claims or other information pertaining to chronic diseases, behavioral health conditions, including alcohol or substance abuse, communicable diseases, including HIV/AIDS, and/or genetic marker information, these records will be included in the information made available to the VCF.

I understand that this authorization is voluntary. However, if you refuse to sign this authorization, the VCF will not be able to process your claim for compensation.

By initialing, I acknowledge that the information described above may include mental health information and I authorize the release of such information. Initial here:

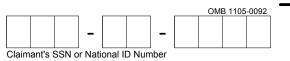
I hereby authorize the person, carrier or other entity listed below to disclose confidential information about the claimant listed below to the VCF, the DOJ and NIOSH:

Section 1 - Name, telephone number and email address for doctors, health care providers or other entities.

octor/Provider/Entity Name										
Doctor/Provider/Entity Address										
Doctor/Provider/Entity Address continued Suite Number										
City										
			(-						
State/Province	Zip/Postal Code	-	Telephone Number							

Physician/Other Entity or Program:





Section 2 - Claimant information and signature.

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Claimant's L	ast Nan	ne																								
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First Name				1				1	1	1	1	1			Midd	lle Na	me	1	1		1					
Mailing Add	ress																									
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Email Addre	SS																									

This information shall be sent to:

September 11th Victim Compensation Fund P.O. Box 34500 Washington, DC 20043





Section 2 - Claimant information and signature continued.

I Certify that I am the person named below (Claimant to the Victim Compensation Fund or Authorized Representative of the Claimant) and I authorize the release of information listed above, including disclosure of information by the WTC Health Program to the VCF, for the purposes of evaluating my claim for compensation under the VCF. I understand that the knowing and willful request for or acquisition of a record pertaining to an individual under false pretenses is a criminal offense subject to a \$5,000 fine.

Signature of Claimant or Authorized Representative(s)

		1			1		
Date	e (m	m/de	d/yy				

Print Name

Relationship to Claimant

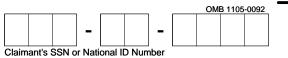
Type of coverage to which this authorization applies (the doctor, health care provider or other entity will indicate all that apply)

⊖ Disability

 \bigcirc Pharmacy

- Long Term Care
- \bigcirc Other. Please specify/describe.





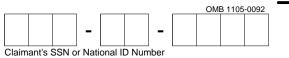
September 11th Victim Compensation Fund Exhibit B1 to the Eligibility Form For Personal Injury Claimants Authorization for Release of Pension Records and Health Information by New York Individuals and Entities

Authorization for Release of Pension and Health Information from HIPAA and Non-HIPAA Entities

Patient Name	Date of Birth	Social Security Number								
Patient Address										
I, or my authorized representative, request that pension and health information be released as set forth on this form: In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:										
1. This authorization may include disclosure of information relating to ALCOHOL and DRUG ABUSE , MENTAL HEALTH TREATMENT , except psychotherapy notes, and CONFIDENTIAL HIV* RELATED INFORMATION only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.										
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.										
3. I have the right to revoke this authorization at any time by writing to the health provider, pension fund or other entity listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.										
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.										
5. Information disclosed under this auth above in Item 2), and this redisclosure r										

6. THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE OR PENSION INFORMATION WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).



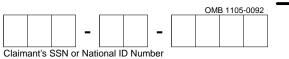


September 11th Victim Compensation Fund Exhibit B1 to the Eligibility Form For Personal Injury Claimants Authorization for Release of Pension Records and Health Information by New York Individuals and Entities

Authorization for Release of Pension and Health Information from HIPAA and Non-HIPAA Entities

 7. Name and address of health provider, pension fund, or other entity to release this information: Please indicate all. New York Office of Payroll Administration (OPA) Room 200N One Centre Street New York, NY 10007 New Work, NY 10007 New York, NY 10007 New York, NY 10279 New York, Fire Department Pension Fund (FIRE) 9 MetroTech Center Brooklyn, NY 11201 New York City Employees' Retirement System (NYCERS) 335 Adams Street, Suite 2300 Brooklyn, NY 11201-3724 Teachers' Retirement System of the City of New York (TRS) 55 Water Street New York, NY 10041 New York, NY 10041 New York, City Board of Education Retirement System (BERS) 65 Court Street, 16th Floor Brooklyn, NY 11201-4965 8. Name and address of person(s) or category of person to whom this information will be sent: September 11th Victim Compensation Fund P.O. Box 34500 Washington, DC 20043 Overnight deliveries can be made to: September 11th Victim Compensation Fund P.O. Box 34500 Washington, DC 20005 	
 Room 200N One Centre Street New York, NY 10007 New York, NY 10007 New York City Police Pension Fund (POLICE) 233 Broadway, 19th Floor New York, NY 10279 New York Fire Department Pension Fund (FIRE) 9 MetroTech Center Brooklyn, NY 11201 New York City Employees' Retirement System (NYCERS) 335 Adams Street, Suite 2300 Brooklyn, NY 11201-3724 Teachers' Retirement System of the City of New York (TRS) 55 Water Street New York, NY 10041 New York City Board of Education Retirement System (BERS) 65 Court Street, 16th Floor Brooklyn, NY 11201-4965 8. Name and address of person(s) or category of person to whom this information will be sent: September 11th Victim Compensation Fund P.O. Box 34500 Washington, DC 20043 Overnight deliveries can be made to: September 11th Victim Compensation Fund Claims Processing Center 1100 L Street N.W Suite 3000 	
 233 Broadway, 19th Floor New York, NY 10279 New York, NY 10279 New York Fire Department Pension Fund (FIRE) 9 MetroTech Center Brooklyn, NY 11201 New York City Employees' Retirement System (NYCERS) 335 Adams Street, Suite 2300 Brooklyn, NY 11201-3724 Teachers' Retirement System of the City of New York (TRS) 55 Water Street New York, NY 10041 New York City Board of Education Retirement System (BERS) 65 Court Street, 16th Floor Brooklyn, NY 11201-4965 8. Name and address of person(s) or category of person to whom this information will be sent: September 11th Victim Compensation Fund P.O. Box 34500 Washington, DC 20043 Overnight deliveries can be made to: September 11th Victim Compensation Fund Claims Processing Center 1100 L Street N.W Suite 3000 	Room 200N One Centre Street
 9 MetroTech Center Brooklyn, NY 11201 New York City Employees' Retirement System (NYCERS) 335 Adams Street, Suite 2300 Brooklyn, NY 11201-3724 Teachers' Retirement System of the City of New York (TRS) 55 Water Street New York, NY 10041 New York City Board of Education Retirement System (BERS) 65 Court Street, 16th Floor Brooklyn, NY 11201-4965 8. Name and address of person(s) or category of person to whom this information will be sent: September 11th Victim Compensation Fund P.O. Box 34500 Washington, DC 20043 Overnight deliveries can be made to: September 11th Victim Compensation Fund Claims Processing Center 1100 L Street N.W Suite 3000 	233 Broadway, 19th Floor
 335 Adams Street, Suite 2300 Brooklyn, NY 11201-3724 Teachers' Retirement System of the City of New York (TRS) 55 Water Street New York, NY 10041 New York City Board of Education Retirement System (BERS) 65 Court Street, 16th Floor Brooklyn, NY 11201-4965 8. Name and address of person(s) or category of person to whom this information will be sent: September 11th Victim Compensation Fund P.O. Box 34500 Washington, DC 20043 Overnight deliveries can be made to: September 11th Victim Compensation Fund Claims Processing Center 1100 L Street N.W Suite 3000 	9 MetroTech Center
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 65 Court Street, 16th Floor Brooklyn, NY 11201-4965 8. Name and address of person(s) or category of person to whom this information will be sent: September 11th Victim Compensation Fund P.O. Box 34500 Washington, DC 20043 Overnight deliveries can be made to: September 11th Victim Compensation Fund Claims Processing Center 1100 L Street N.W Suite 3000 	55 Water Street
September 11th Victim Compensation Fund P.O. Box 34500 Washington, DC 20043 Overnight deliveries can be made to: September 11th Victim Compensation Fund Claims Processing Center 1100 L Street N.W Suite 3000	65 Court Street, 16th Floor
P.O. Box 34500 Washington, DC 20043 Overnight deliveries can be made to: September 11th Victim Compensation Fund Claims Processing Center 1100 L Street N.W Suite 3000	8. Name and address of person(s) or category of person to whom this information will be sent:
September 11th Victim Compensation Fund Claims Processing Center 1100 L Street N.W Suite 3000	P.O. Box 34500
	September 11th Victim Compensation Fund Claims Processing Center 1100 L Street N.W Suite 3000





September 11th Victim Compensation Fund Exhibit B1 to the Eligibility Form For Personal Injury Claimants Authorization for Release of Pension Records and Health Information by New York Individuals and Entities

Authorization for Release of Pension and Health Information from HIPAA and Non-HIPAA Entities

9(a). Specific information to be released:	halvda (haliaa (a hal mitia k aa)								
Complete Pension File, including, but not I Information regarding the type of pension a (ADR, ODR or service), the amount, and v not the benefit was awarded pursuant to th Disability Law.	awarded Alcohol/Drug Treatment								
Authorization to Discuss Health or Pension Inform	HIV Related Information								
9(b). O By initialing here (Initials), I authorize	9								
The individuals and entities identified in Ques	tion #7								
(Name of individual health care provider, pens	ion fund or other entity)								
to discuss my health or pension-related information with my attorney, or a governmental age listed here: <u>September 11th Victim Compensation Fund and the United States Department of Justice</u> (Attorney/Firm Name or Governmental Agency Name)									
 10. Reason for release of information: O At request of individual 	11. Date or event on which this authorization will expire:								
 Other: To evaluate my claim for compensation with the September 11th Victim Compensation Fund 	Six (6) years from the date of signature or upon my written termination								
12. If not the claimant, name of person signing form:	13. Authority to sign on behalf of claimant:								

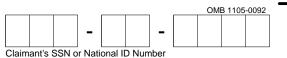
All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

Signature of claimant or representative authorized by law

Date:

* Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.





September 11th Victim Compensation Fund Exhibit C to the Eligibility Form For Personal Injury Claimants Attorney Certification of Compliance with Provision on Limitation on Attorney Fees (Section 104.81)

If Claimant has been represented by an attorney for services rendered in connection with this claim, **Claimant's attorney must complete the following certification:**

I hereby certify that:

(1) The amount I have charged or will charge for the services I have rendered in connection with this claim, including expenses routinely incurred in the course of providing legal services, is not more than 10 percent of an award that might be paid on this claim; **AND**

(2) I have not charged nor will I charge for any expenses incurred in connection with this claim that are not routinely incurred in the course of providing legal services, unless the Special Master has approved such expenses; **AND**

(3) One of the following statements is true concerning a civil action brought by or on behalf of the Claimant for damages sustained as a result of the terrorist-related aircraft crashes of September 11, 2001 or for damages arising from or related to debris removal (excluding civil actions to recover collateral source obligations or against any person who is a knowing participant in any conspiracy to hijack or commit any terrorist act) that was commenced after December 22, 2003 in which a release of all claims in such action was tendered prior to January 2, 2011:

- I did not charge a legal fee in connection with a settlement of this Claimant's claim(s) in such an action;
 OR
- I charged a legal fee in connection with a settlement of this Claimant's claim(s) in such an action that was 10 percent or more of the aggregate amount of compensation awarded though such settlement, and I have not charged nor will I charge for any services rendered in connection with this claim with the VCF; OR
- I charged a legal fee in connection with a settlement of this Claimant's claim(s) in such an action that was less than 10 percent of the aggregate amount of compensation awarded though such settlement, and the amount I have charged or will charge for the services I have rendered in connection with this claim with the VCF does not exceed the difference between 10 percent of such aggregate amount and the total amount of all legal fees I charged for services rendered in connection with such settlement.

I declare under penalty of perjury that the foregoing is true and correct.

Ex	ecut	ed c	n th	is [day	/ of							,	201].						
Sig	Signature of Attorney																						
Attor	ney's	Nam	ie										 					 			I		
Attor	Attorney's Firm/Address																						
Attor	ney's	Firm	/Addi	ess (contin	ued													1	Suite	i		
City				1	1	1	1	1		1		1			1						<u> </u>	I]
State	;	-	Zip/I	Posta	al cod	e																	
5	5870)628	8680)																			



Compensation Form Exhibit 1

Social Security Administration Consent for Release of Information and Request for Social Security Earnings Information

The September 11th Victim Compensation Fund (VCF) will contact the Social Security Administration (SSA) directly to request information that is pertinent to determining your VCF compensation award. In order to request the information from the SSA, this cover page and the two (2) attached forms must be completed, signed, and returned to the VCF. Please carefully follow the instructions below when completing these forms.

- **Step 1:** Write the Claimant or Decedent Name, VCF Claim Number, and Social Security Number in the designated spaces at the bottom of this page.
- Step 2: Review the two-page "Social Security Administration Consent for Release of Information" form. To make it easier for you to complete this form, the VCF has already completed many of the required sections. Please fill in the following information on <u>Page 2</u> of the form:
 - Write the Claimant's or Decedent's Name, Date of Birth, and Social Security Number in the spaces at the top of the page.
 - Complete the section at the bottom of the page by signing, dating, and providing your daytime phone number.
 - If you are not the Claimant (i.e., if you are completing this form as the Personal Representative of a Decedent or as the Authorized Representative of an injured Claimant), please indicate your relationship to the Claimant in the "Relationship" field.
- **Step 3:** Review the four-page "Request for Social Security Earnings Information" form. To make it easier for you to complete this form, the VCF has already completed many of the required sections and has marked certain sections as "Not Applicable". Please fill in the following information on <u>Page 2</u> of the form:
 - <u>Section 1</u>: Write the Claimant's or Decedent's Name, Social Security Number, Other Name(s) Used (if applicable), and Date of Birth in the spaces provided.
 - Section 4: Sign, date, and write your daytime phone number.

You do not need to complete any other parts of this form.

Step 4: Upload this page and <u>both</u> signed SSA forms in their entirety to your online claim and select "Exhibit 1: Social Security Administration Form" as the document type. If you filed a hard copy claim, mail the forms to:

> September 11th Victim Compensation Fund PO Box 34500 Washington, DC 20043

Please do NOT send these forms directly to the Social Security Administration. Doing so may delay the processing of your VCF claim.

Claimant or Decedent Full Name: _____

VCF Claim Number: VCF _____

Claimant or Decedent Social Security Number: _____

Social Security Administration Consent for Release of Information

Instructions for Using this Form

Complete this form only if you want us to give information or records about you, a minor, or a legally incompetent adult, to an individual or group (for example, a doctor or an insurance company). If you are the natural or adoptive parent or legal guardian, acting on behalf of a minor, you may complete this form to release only the minor's non-medical records. If you are requesting information for a purpose not directly related to the administration of any program under the Social Security Act, a fee may be charged.

NOTE: Do not use this form to:

- Request us to release the medical records of a minor. Instead, contact your local office by calling 1-800-772-1213 (TTY-1-800-325-0778), or
- Request information about your earnings or employment history. Instead, complete form SSA-7050-F4 at any Social Security office or online at <u>www.ssa.gov/online/ssa-7050.pdf</u>.

How to Complete this Form

We will not honor this form unless all required fields are completed. An asterisk (*) indicates a required field. Also, we will not honor blanket requests for "all records" or the "entire file." You must specify the information you are requesting and you must sign and date this form.

- Fill in your name, date of birth, and social security number or the name, date of birth, and social security number of the person to whom the information applies.
- · Fill in the name and address of the individual (or organization) to whom you want us to release your information.
- · Indicate the reason you are requesting us to disclose the information.
- · Check the box(es) next to the type(s) of information you want us to release including the date ranges, if applicable.
- You, the parent or legal guardian acting on behalf of a minor, or the legal guardian of a legally incompetent adult, must sign and date this form and provide a daytime phone number where you can be reached.
- If you are not the person whose information is requested, state your relationship to that person. We may require proof of relationship.

PRIVACY ACT STATEMENT

Section 205(a) of the Social Security Act, as amended, authorizes us to collect the information requested on this form. The information you provide will be used to respond to your request for SSA records information or process your request when we release your records to a third party. You do not have to provide the requested information. Your response is voluntary; however, we cannot honor your request to release information or records about you to another person or organization without your consent.

We rarely use the information provided on this form for any purpose other than to respond to requests for SSA records information. However, in accordance with 5 U.S.C. § 552a(b) of the Privacy Act, 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 an agency or third party to assist Social Security in establishing rights to Social Security benefits and/or coverage; 2. To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level; 3. To comply with Federal laws requiring the disclosure of the information from our records; and, 4. To facilitate statistical research, audit, or investigative activities necessary to assure the integrity of SSA programs.

We may also use the information you provide when we match records by computer. Computer matching programs compare our records with those of 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.

Additional information regarding this form, routine uses of information, and other Social Security programs are available from our Internet website at <u>www.socialsecurity.gov</u> 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 <u>Paperwork</u> <u>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 3 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 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 not honor this form unless all required fields have been completed (*signifies required field).

TO: Social Security Administration

*Name *[Date of Birth	*Social Security Number								
I authorize the Social Security Adminis	tration to release inforr	nation or records about me to:								
*NAME	*ADDRESS									
U.S. Department of Justice	September 11th Victim	Compensation Fund								
	P. O. Box 34500, Wash	nington, DC 20043								
*I want this information released because: <u>There may be a charge for releasing information.</u> Fund for the purpose of evaluating my claim with the VCF.										
*Please release the following informat You must check at least one box. Also, SSA will no Social Security Number										
Current monthly Social Security be	enefit amount									
Current monthly Supplemental Sec	urity Income payment am	iount								
X My benefit/payment amounts from	My DOB to P	resent								
My Medicare entitlement from	to									
Medical records from my claims fo		d contact your local SSA office.								
X Complete medical records from my	v claims folder(s)									
	Other record(s) from my file (e.g. applications, questionnaires, consultative examination reports, determinations, etc.) including applications, questionnaires, determinations and diagnosis codes									

I am the individual to whom the requested information/record applies, or the parent or legal guardian of a minor, or the legal guardian of a legally incompetent adult. I declare under penalty of perjury in accordance with 28 C.F.R. § 16.41(d)(2004) 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 or willfully seeking or obtaining access to records about another person under false pretenses is punishable by a fine of up to \$5,000. I also understand that any applicable fees must be paid by me.

*Signature:	*Date:	
Relationship (if not the individual):	*Daytime Phone:	
5-55		

Form SSA-3288 (07-2010) EF (07-2010)

REQUEST FOR SOCIAL SECURITY EARNINGS INFORMATION

*Use This Form If You Need

1. Certified/Non-Certified Detailed Earnings Information

Includes periods of employment or self-employment and the names and addresses of employers.

OR

2. Certified Yearly Totals of Earnings

Includes total earnings for each year but does not include the names and addresses of employers. DO NOT USE THIS FORM FOR:

Non-certified yearly totals of earnings

This service is free to the public.

These totals can be obtained by calling 1-800-772-1213 to receive Form SSA-7004, Request for Social Security Statement

PRIVACY ACT NOTICE: We are authorized to collect this information under section 205 of the Social Security Act, and the Federal Records Act of 1950 (64 Stat. 583). It is needed so we can identify your records and prepare the statement you request. You do not have to furnish the information, but failure to do so may prevent your request from being processed.

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 11 minutes to read the instructions, gather the facts, and answer the questions. *Send <u>only</u> comments relating to our time estimate above to:* SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.

INFORMATION ABOUT YOUR REQUEST

How Do I Get This Information?

You need to complete the attached form to tell us what information you want.

· Can I Get This Information For Someone Else?

Yes, if you have their written permission. For more information, see page 3.

• Who Can Sign On Behalf Of The Individual?

The parent of a minor child, or the legal guardian of an individual who has been declared legally incompetent, may sign if he/she is acting on behalf of the individual.

Is There A Fee For This Information?

1 Cortified/Non Cortified Detailed Earnings Information

Kes, we usually charge a fee for detailed information. In most cases, this information is used for purposes NOT directly related to social Security such as for a private pension plan or personal injury said. The fraction mage 3 gives the annotif the policable

Sometimes, there is no charge for detailed information. If you have reason to believe your earnings are not correct (for example, you have previously received earnings information from as and it does not agree with your records), we will supply you with more detail for the period in question. Occasionally, earnings amounts are wrong because an employer did not correctly report earnings or earnings are credited to the wrong person. In situations like these, we will send you detailed information, at no charge, so we can correct your record.

Be sure to show the year(s) involved on the request form and explain why you need the information. If you do not tell us why you need the information, we will charge a fee.

We Not if Applicable rmation for an additional police of the call of the second second

usually not necessary unless you plan to use the information in court.

2. Certified Yearly Totals of Earnings

Yes, there is a fee of \$15 to certify yearly totals of earnings. Certification is usually not necessary unless you plan to use the information in court.

3. Method of Payment

Enclose a check or money order for the entre fee required. Payment can also be made by oredit card. To do so, complete page 4 of this form and return it with your request form.

REQUEST FOR SOCIAL SECURITY EARNINGS INFORMATION

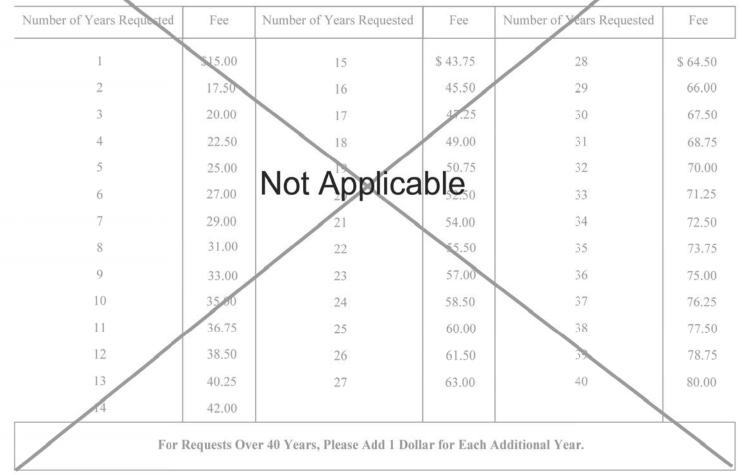
1. From	n whose record do you need the earnings information	on?
Print	t the Name, Social Security Number (SSN), and dat	e of birth below.
Nam	е	Social Security Number
	er Name(s) Used ude Maiden Name)	Date of Birth (Mo/Day/Yr)
2. Wha	t kind of information do you need?	
X	Detailed Earnings Information (If you check this block, tell us below why you need this information.) It relates to my claim with the Victim Compensati	For the period(s)/year(s): <u>1998 to present</u>
	evaluating my claim with the VCF.	
	Certified Yearly Totals of Earnings	For the year(s):
	(Check this box only if you want the information certified. Otherwise, call 1-800-772-1213 to request Form SSA-7004, Request for Social Security Statement)	
3. If yo	u owe us a fee for this detailed earnings informatio	n, enter the amount due
using	g the chart on page 3	A. \$ <u>N/A</u>
Do y	you want us to certify the information?	🗌 Yes 🗌 No
lf	f yes, enter \$15.00	B.\$ <u>N/A</u>
) the amounts on lines A and B, and r the TOTAL amount	
		empleting and returning the form on page 4, or R for the amount on line C with the request and to "Social Security Administration"
indiv	the individual to whom the record pertains (or a peridual). I understand that any false representation to al Security records is punishable by a fine of not m	knowingly and willfully obtain information from
SIGN	N your name here (Do not print) >	Date
Day	time Phone Number (Area Code) (Telephone Number)	
5. Tell u	us where you want the information sent. (Please pr	int)
Nam	u.S. Department of Justice A	ddress September 11th Victim Compensation Fund
City,	, State & Zip Code P. O. Box 34500, Washington, I	DC 20043
6. Mail	Completed Form(s) To: Exception: If u	sing private contractor (e.g., FedEx) to mail form(s), use:
Divis P.O.	sion of Earnings Record OperNOLAPPIIC Box 33003	al Security Administration AO Conings Record Operations N. Greene St. more, Maryland 21290-0300
	A-7050-F4 (07-2010) EF (07-2010) 2	

REQUEST FOR SOCIAL SECURITY EARNINGS INFORMATION

How Much Do I Have to Pay For Detailed Earnings?

1. Count the number of years for which you need detailed earnings information. Be sure to add in both the first and last year requested. However, do not add in the current calendar year since this information is not yet available.

2. Use the chart below to determine the correct fee.



• Whose Earnings Can Be Requested

1. Your Earnings

You can request earnings information from your own record by completing the attached form; we need your handwritten signature. If you sign with an "X", your mark must be witnessed by two disinterested persons who must sign their name and address.

2. Someone Else's Earnings

You can request earnings information from the record of someone else if that person tells us in writing to give the information to you. This writing or "authorization" must be presented to us within 60 days of the date it was signed by that person.

3. A Deceased Person's Earnings

You can request earnings information from the record of a deceased person if you are the legal representative of the estate, a survivor (that is, the spouse, parent, child, divorced spouse of divorced parent), or an individual with a material interest (example-financial) who is an heir at law, next of kin, beneficiary under the will or donee of property of the decedent.

Proof of death must be included with your request. Proof of appointment as representative or proof of your relationship to the deceased must also be included.

As a convenience, we offer you the option to make your paym	AYMENT BY CREDIT CARD ent by credit card. However, regular credit card rules will apply y check or money order.
Please fill in all the information below and return this form along with your request to: Social Security Administration Division of Earning: Record Operations P.O. Box 33003 Baltimore, Maryland 21290-3003	Exception: If using private contractor (e.g., FedEx) to mail form(s), use: Social Security Administration Division of Earnings Record Operations 300 N. Greene St. Baltimore, Maryland 21290-0300
	rwork/Privacy Act Notice
	MasterCard Discover Diners Card
(Enter the name from the credit card)	plicable
Credit Card Holder's Address	Number & Street City, State, & Zip Code
Daytime Telephone Number	Area Code Telephone Number
Credit Card Number	
Credit Card Expiration Date	Month
Amount Charged	\$
Creat Card Holder's Signature	
	Authorization
DO NOT WRITE IN THIS SPACE OFFICE USE ONLY	Name Date
	Remittance Control #

PRIVACY ACT NOTICE

The Social Security Administration (SSA) has authority to collect the information requested on this form under section 205 of the Social Security Act. Giving us this information is voluntary. You do not have to do it. We will need this information only if you choose to make payment by credit card. You do not need to fill out this form if you choose another means of payment (for example, by check or money order).

If you choose the credit card payment option, we will provide the information you give us to the banks handling your credit card account and SSA's account. We may also provide this information to another person or government agency to comply with federal laws requiring the release of information from our records. You can find these and other routine uses of information provided to SSA listed in the Federal Register. If you want more information about this, you may call or write any Social Security Office.