

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/BENEFICIARY IF OTHER THAN CUSTOMER |

| | | |
|--|---|---|
| ACCOUNT NUMBER(S) | <input type="checkbox"/> JOINT ACCOUNT | <input type="checkbox"/> JOINT ACCOUNT |
| <input type="checkbox"/> JOINT ACCOUNT <input type="checkbox"/> DIRECT DEPOSIT | <input type="checkbox"/> DIRECT DEPOSIT | <input type="checkbox"/> DIRECT DEPOSIT |

I understand:

- I have the right to revoke this authorization at any time before any records are disclosed;
- The Social Security Administration may request all records about me from any financial institution;
- Any information obtained will be kept confidential;
- 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
- This authorization is not required as a condition of doing business with any financial institution.

The checkbox below shows the reason you are giving us your authorization to contact financial institutions:

- Supplemental Security Income Eligibility
- The Social Security Administration will request records to determine initial or continuing eligibility and the accuracy of the payment for Supplemental Security Income (SSI) benefits.
 - If I am an applicant or recipient, failing to provide or revoking my authorization will result in a denial or suspension of SSI benefits.
 - 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.
 - This authorization is in effect until the earliest of: 1) a final adverse decision on my application for benefits, 2) the cessation of my eligibility for benefits, or 3) my revocation of this authorization in a written notification to the Social Security Administration.

- Waiver Determination
- The Social Security Administration will request records to determine the ability to repay an overpayment in conjunction with a waiver determination.
 - Failing to provide or revoking my authorization may result in the Social Security Administration determining, on that basis, that adjustment or recovery of the overpayment will not deprive me of funds to pay my bills for food, clothing, housing, medical care, or other necessary expenses.
 - This authorization is in effect until the earliest of: 1) a final decision on whether adjustment or recovery of my overpayment would deprive me of funds to pay my bills for food, clothing, housing, medical care, or other necessary expenses; or 2) my revocation of this authorization in a written notification to the Social Security Administration.

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 |

Customer's Name:

Social Security Number:

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 (12 U.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
REPRESENTATIVETELEPHONE NO.
(INCLUDE AREA CODE)

DATE

ADDRESS

REQUEST FOR RECORDS

This request is authorized by sections 204(b), 1631(b)(1)(B) and 1631 (e)(1)(B) of the Social Security Act, as amended. While you are not required to respond, your cooperation will help us either to: (1) determine the eligibility of the applicant or recipient named above for Supplemental Security Income benefits; or (2) determine if a request to waive a Social Security overpayment should be granted. 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

Customer's Name:

Social Security Number:

| Month/Year | ACCOUNT 1 | | ACCOUNT 2 | | ACCOUNT 3 | |
|------------|-----------|---------------|-----------|---------------|-----------|---------------|
| | 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**~~

See Revised Privacy Act &
PRA Statements attached

~~Sections 204(b), 1631(b)(1)(B), and 1631(e)(1)(B) of the Social Security Act, as amended, allow us to collect this information. Furnishing us this information is voluntary. However, failing to provide all or part of the information may prevent us from making an accurate and timely decision on benefit eligibility or from waiving an overpayment.~~

~~We will use this information to verify eligibility for benefits or to assist us in waiving a Social Security overpayment. We may also share your information for the following purposes, called routine uses:~~

- ~~• Disclosure to contractors and other Federal agencies, as necessary, for the purpose of assisting the Social Security Administration (SSA) in the efficient administration of its programs; and~~
- ~~• To student volunteers and other workers, who technically do not have the status of Federal employees, when they are performing work for SSA.~~

~~In addition, we may share this information in accordance with the Privacy Act and other Federal laws. For example, where authorized, we may use and disclose this information in computer matching programs, in which our records are compared with other records to establish or verify a person's eligibility for Federal benefit programs and for repayment of incorrect or delinquent debts under these programs.~~

~~A list of additional routine uses is available in our Privacy Act System of Records Notices (SORN) 60-0094, entitled Recovery of Overpayments Accounting and Reporting/Debt Management System, as published in the Federal Register (FR) on August 23, 2005, at 70 FR 49354 and 60-0103, entitled Supplemental Security Income Record and Special Veterans Benefits, as published in the FR on January 1, 2006, at 71 FR 1830. Additional information, and a full listing of all of our SORNs, is available on our website at www.ssa.gov/privacy.~~

~~**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.**~~