WORKERS' COMPENSATION/PUBLIC DISABILITY BENEFIT QUESTIONNAIRE

NAME OF WORKER	SOCIAL SECURITY NUMBER

1. What type of benefit are you receiving, did you receive or do you expect to receive in connection with your disability?

WORKERS' COMPENSATION:

- ☐ Workers' Compensation - State (including occupational disease payments)
- ☐ Black Lung Benefits
- ☐ Longshore and Harbor Workers' Compensation
- ☐ Federal Employees' Compensation (FECA- workers' compensation for Federal employees)

PUBLIC DISABILITY BENEFITS:

- ☐ Civil Service Disability or Federal Employees' Retirement System (FERS) Disability Benefits
- ☐ State Temporary Disability Payments
- ☐ Federal, State or Local Government Employee Disability Benefits
- ☐ Other: _____

2. For each benefit checked above, enter the claim number, employer, insurance carrier and date of injury/illness.

TYPE OF BENEFIT	CLAIM NUMBER	EMPLOYER	INSURANCE CARRIER	DATE OF INJURY/ ILLNESS

3. Indicate the State in which you worked when these benefits began or, if workers' compensation is one of the benefits involved, the State in which the injury occurred.

STATE

4. If you are receiving one of the public disability benefits listed in item 1, were Social Security taxes always paid on your earnings? ☐ Yes ☐ No (If "No," explain. For example, you were a federal, State or local government employee whose earnings were not covered or were not always covered by Social Security.) _____

5. Indicate the status of your claim for workers' compensation or other public disability benefits. If you are receiving more than one type of benefit, indicate the status of each claim.

- ☐ a. Filed for Benefits, or Intend to File but not yet Entitled
- ☐ b. Filed for Benefits, but Claim was Denied
- ☐ c. Claim Denied; Appeal Pending (if appeal is pending, give date you expect a decision.) _____
- ☐ d. Currently Receiving Benefits
- ☐ e. Received Payments in the Past but not Presently
- ☐ Other (e.g., lump-sum payment) _____
  Explain: _____

If a., b., or c. is checked, go on to Item 11 (signature block). If d., e., or f. is checked, complete the remainder of the form.

6. How are (or were) those disability payments made?

☐ Weekly ☐ Monthly ☐ Every Two Weeks ☐ Other (Explain): _____

7. a. List the amount(s) and the period(s) of time for which those disability benefits were made. (if only lump-sum payment was made, see item 8.)

TYPE OF BENEFIT	AMOUNT	FROM	TO

b. If those payments have stopped, indicate the reason:

- ☐ Lump-Sum Settlement Pending
- ☐ Permanent Rating Pending
- ☐ Appeal Pending
- ☐ Other (Explain in item 10, "Remarks")

c. Do you expect those payments to begin again? ☐ Yes ☐ No

If "Yes", When _____

8. Have you ever received or been awarded a lump-sum settlement (including "compromise and release" or similar type of settlement)? ☐ Yes (If "Yes", complete item 9) ☐ No

9. Lump-sum payment:

a. Date(s) settlement(s) or award(s) made	b. Gross Amount(s)
	$

c. The lump sum represents:

$ per week for weeks beginning

d. The amount shown in 9.b. (Gross amount) includes:

(1) MEDICAL EXPENSES OF	(2) ATTORNEY FEES OF	(3) RELATED EXPENSES OF
$	$	$

10. Remarks:

IMPORTANT INFORMATION. PLEASE READ THE FOLLOWING CAREFULLY.

I agree to report if I apply for or begin to receive a workers' compensation (including black lung benefits) or a public disability benefit or the amount that I am receiving changes or stops, or I receive a lump-sum settlement. I understand that such benefits may affect my Social Security payments or result in an overpayment which I may have to pay back. 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 makes or causes to be made a false statement or representation of material fact for use in determining a payment under the Social Security Act, or knowingly conceals or fails to disclose an event with an intent to affect an initial or continued right to payment, or submits or causes to be submitted any false statement or document knowing the same to contain any misrepresentation of material fact, commits a crime punishable under Federal law by fine, imprisonment, or both, and may be subject to administrative sanctions.

DATE	TELEPHONE NUMBERS(S) at which you may be contacted during the day

MAILING ADDRESS (Number Street, Apt. No., P.O. Box., Rural Route)

CITY AND STATE	ZIP CODE

Privacy Act Statement
Collection and Use of Personal Information

Section 224 of the Social Security Act, as amended, allows us to collect your information, which we will use to determine the effect of your worker's compensation or other public disability benefit on your Social Security disability insurance benefits. Providing this information is voluntary, but not providing all or part of the information may prevent an accurate and timely decision regarding benefits eligibility. As law permits, we may use and share the information you submit, including with other Federal agencies, contractors, and others, as outlined in the routine uses within System of Records Notices (SORN) 60-0089 and 60-0090, available at www.ssa.gov/privacy. The information you submit may also be used in computer matching programs to establish or verify eligibility for Federal benefit programs and to recoup debts under these programs.

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 (OMB) control number. We estimate that it will take about 30 minutes to read the instructions, gather the facts, and answer the questions. ***Send only comments regarding this burden estimate or any other aspect of this collection, including suggestions for reducing this burden to:*** *SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.*