

**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 REPRESENTATIVE 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 NUMBER (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 <sup>1</sup>                                  |           |           |           |           |
| ACCOUNT NUMBER  |           |           |           |           |
| NAME(S) ON AND EXACT ACCOUNT DESIGNATION                      |           |           |           |           |
| BALANCE AS OF<br><hr style="width: 100%; margin: 0;"/> (Date) |           |           |           |           |
| BALANCE AS OF<br><hr style="width: 100%; margin: 0;"/> (Date) |           |           |           |           |

<sup>1</sup> 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

## Privacy Act Statement Collection and Use of Personal Information

~~Section 1860D-14(a)(3) of the Social Security Act, as amended, allows us to collect this information. Furnishing us this information is voluntary. However, failing to provide all or part of the information may prevent an accurate and timely decision on Medicare Part D benefits eligibility or continuing eligibility.~~

~~We will use the information you provide to obtain account records from a financial institution to review the accuracy of the eligibility and subsidy amount of Medicare Part D benefits. We may also share the information for the following purposes, called routine uses:~~

- ~~• To applicants, claimants, prospective applicants or claimants (other than the data subjects and their authorized representatives) to the extent necessary for the purpose of pursuing Medicare Part D and Part D subsidy entitlement or appeal rights; and~~
- ~~• To the Centers of Medicare and Medicaid Services (CMS), for the purpose of administering Medicare Part D enrollment and premium collection and Medicare Advantage Part C premium collections, as well as, Medicare Part B income-related monthly adjustment amounts.~~

~~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 Notice (SORN) 60-0321, entitled Medicare Database (MDB) File, as published in the Federal Register (FR) on July 25, 2006, at 71 FR 42159. Additional information, and a full listing of all of our SORNs, is available on our website at <http://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 (OMB) control number. We estimate that it will take about 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. ***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.***