Social Security Administration

Form Approved
OMB No. 0960-0566

Consent for Release of Information

*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 Administration to release information or records about me to:

*NAME	*ADDRESS
State of California Subsequent Injury	160 Promenade Circle Ste 350
Benefits Trust Fund (SIBTF)	Sacramento, CA 95834

*I want this information released because: **State of California needs this information to determine my eligibility for the Subsequent Injury Benefits Trust Fund.**

There may be a charge for releasing information.

THIS REQUEST IS FOR DISABILITY INFORMATION ONLY

*Please release the following information selected from the list below:

You must check at least one box. Also, SSA will not disclose records unless applicable date ranges are included.

- [ ] Social Security Number
- [ ] Current monthly Social Security benefit amount
- [ ] Current monthly Supplemental Security Income payment amount
- [x] My benefit/payment amounts from **SSD Start** to **Present**
- [ ] My Medicare entitlement from ____________ to ____________
- [ ] Medical records from my claims folder(s) from ____________ to ____________
  If you want SSA to release a minor's medical records, do not use this form but instead contact your local SSA office.
- [ ] Complete medical records from my claims folder(s)
- [ ] Other record(s) from my file (e.g. applications, questionnaires, consultative examination reports, determinations, etc.) ____________

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: X____________________ *Date: X____________

Relationship *(if not the individual)*: X____________ *Daytime Phone:X____________

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

REQUEST FOR PENSION INFORMATION

APPLICANT: Please complete all blanks in the **top portion** of the form.

APPLICANT: ______________________________
Signature

I hereby grant permission to release **disability pension** information to the Subsequent Injury Benefits Trust Fund of the State of California.

Name ______________________________

Address: ______________________________

____

Birth Date: _____/_____/_____

Social Security #: ________ - ______ - ________

Union Local #: ________

COMPANY PENSION PLAN OR
LONG TERM **DISABILITY** PROVIDER:

____

Administered by: ______________________________

Address: ______________________________

____

Union Name: ______________________________

Address: ______________________________

____

____

****************************** **APPLICANT STOP HERE** ********************************

PENSION REPRESENTATIVE: The State of California, Division of Workers' Compensation, Subsequent Injuries Fund requires information regarding my pension. Please complete the verification below for its confidential use.

1. Commencement Date of **DISABILITY** pension or Long Term **Disability**: _____/_____/_____
2. Medical conditions **(disability)** considered at the time of pension/LTD:

____

3. The amount of the initial monthly **disability** benefit, and the effective date and amount of any changes:

____

4. If the member were NOT **disabled**, would the member be eligible for regular retirement benefits now, in the past, or in the future?
No ( ) Yes ( ) If "yes", what would the first date of regular retirement be and what monthly benefit amount?

____

5. Will this member have a right to convert to REGULAR retirement at a later date?
No ( ) Yes ( ) If "yes" what would be the first date and what monthly benefit amount?

____

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COMPLETED BY: ______________________________ DATE: ____________________

TITLE: ______________________________ PHONE: ( ) ____________________

PLEASE RETURN THE COMPLETED FORM TO:
SUBSEQUENT INJURIES FUND
Division of Workers' Compensation
160 Promenade Circle, #350
Sacramento, CA 95834

DWC SIF 60 3/91