Form Approved
OMB No. 0960-0247

WORKERS' COMPENSATION/PUBLIC DISABILITY BENEFIT QUESTIONNAIRE

NAME OF WORKER	SOCIAL SECURITY NUMBER

Privacy Act Statement

Collection and Use of Personal Information

Section 224 of the Social Security Act, as amended, authorizes us to collect this information. We will use this information to determine the effect of your worker's compensation or other public disability benefit on your Social Security disability insurance benefits.

Furnishing us this information is voluntary. However, failing to provide us with all or part of the information could prevent us from making an accurate and timely decision on your benefit eligibility.

We rarely use the information you supply for any purpose other than for determining the effect of other disability benefits on your Social Security benefits. However, we may use it for the administration and integrity of Social Security programs. We may also disclose information to another person or to another agency in accordance with approved routine uses, which include but are not limited to the following:

1. To enable a third party or an agency to assist Social Security in establishing rights to Social Security benefits and/or coverage;
2. To comply with Federal laws requiring the release of information from Social Security records (e.g., to the Government Accountability Office and Department of Veterans' Affairs);
3. To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level; and,
4. To facilitate statistical research, audit, or investigative activities necessary to assure the integrity and improvement of Social Security programs (e.g., to the Bureau of the Census and private concerns under contract to Social Security).

We may also use the information you provide in computer matching programs. Matching programs compare our records with records kept by 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.

A complete list of routine uses for this information is available in Systems of Records Notices entitled, Claims Folder Record, 60-0089, and Master Beneficiary Record, 60-0090. These notices, additional information regarding this form, and information regarding our programs and systems, are available on-line at www.socialsecurity.gov 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 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 12.5 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. The office is listed under U. S. Government agencies in your telephone directory or you may call Social Security at 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 only comments relating to our time estimate to this address, not the completed form.***

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 pend- ing, give date you expect a decision.)
Date _____

d. ☐ Currently Receiving Benefits

e. ☐ Received Payments in the Past but not Presently

f. ☐ 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 ☐ Appeal Pending

☐ Permanent Rating Pending ☐ Other (Explain in item 10, "Remarks")

c. Do you expect those payments to begin again? ☐ Yes ☐ No | IF "YES", WHEN (Date)

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 AND SIGN BELOW

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 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. I understand that anyone who knowingly gives a false or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime and may be sent to prison, or may face other penalties, or both.**

SIGNATURE OF PERSON MAKING STATEMENT | DATE

SIGNATURE (First Name, Middle Initial, Last Name) (Write in Ink)
SIGN HERE ▶ | 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

Witnesses are required ONLY if this form has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the person requesting reconsideration must sign below, giving their full addresses.

(1) SIGNATURE OF WITNESS	(2) SIGNATURE OF WITNESS
ADDRESS (Number and Street, City, State and ZIP Code)	ADDRESS (Number and Street, City, State and ZIP Code)