WORKERS' COMPENSATION/PUBLIC DISABILITY BENEFIT QUESTIONNAIRE

NAME OF WORKER	SOCIAL SECURITY NUMBER

PRIVACY ACT/PAPERWORK ACT NOTICE: Your responses to this request is voluntary; however, failure to provide all or part of the requested information could prevent an accurate and timely decision on this claim and could affect your Social Security benefits. The Social Security Administration uses the information you furnish to determine the effect of your worker's compensation or other public disability benefit on your Social Security disability insurance benefits, as provided in section 224 of the Social Security Act (42 U.S.C. 424). The information on this form may be disclosed by the Social Security Administration to another person or agency for the following purposes: (1) to assist the Social Security Administration in establishing the right of a beneficiary to Social Security benefits; (2) to facilitate statistical research and audit activities necessary to assure the integrity and improvement of the Social Security programs; and (3) to comply with laws requiring the exchange of information between the Social Security Administration and another agency.
We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it.

These and other reasons why information about you may be used or given out are explained in the Federal Register. If you want to learn more about this, contact any Social Security Office.

TIME IT TAKES TO COMPLETE THIS FORM
We estimate that it will take you about 12.5 minutes to complete this form. This includes the time it will take to read the instructions, gather the necessary facts and fill out the form. If you have comments or suggestions on this estimate, or on any other aspect of this form, write the Social Security Administration, ATTN: Reports Clearance Officer, 1-A-21 Operations Bldg., Baltimore, MD 21235-0001, and to the Office of Management and Budget, paperwork Reduction Project (0960-0247), Washington, D.C. 20503. Send only comments relating to our estimate or other aspects of this form to the offices listed above. All requests for Social Security cards and other claims related information should be sent to your local Social Security office, whose address is listed in you telephone directory under the Department of Health and Human Services.

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.3

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.)
Date _____

d. ☐ Currently Receiving Benefits

e. ☐ Received Payments in the Past but not Presently Receiving Them

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 know that anyone who makes or causes to be mode a false statement or representation of material fact in an application or for use in determining a right to payment under the Social Security Act commits a crime punishable under Federal law by fine, imprisonment or both. I affirm that all information I have given in this document is true.

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)