

REQUEST FOR SOCIAL SECURITY DISABILITY BENEFIT INFORMATION

**FLORIDA DEPARTMENT OF FINANCIAL SERVICES
DIVISION OF WORKERS' COMPENSATION**

(To be filed with the Social Security Office nearest to the Employee's Address)

RECEIVED BY CLAIMS- HANDLING ENTITY

PLEASE PRINT OR TYPE

I. IDENTIFICATION OF PARTIES (To be completed by requesting party)

Employee's Social Security No. ████	Employee's Name (First, Middle, Last)	Date of Accident: (Month-Day-Year)
Employee's Address	Employer's Firm Name & Address	Claims-handling entity's Name & Address
		Claims-handling entity File No.

II. EMPLOYEE'S AUTHORIZATION FOR RELEASE (To be completed and dated by employee)

Notice to Employee - This form has been provided to you to supply your AUTHORIZATION FOR RELEASE OF INFORMATION. The Workers' Compensation Act F.S. 440.15(9)(c) requires you to furnish this Authorization. SHOULD YOU REFUSE TO SIGN AND RETURN THIS FORM WITHIN 21 DAYS AFTER THE DATE OF RECEIPT, YOUR WORKERS' COMPENSATION PAYMENTS MAY STOP until you comply with this request.

To allow determination of the proper amount of workers' compensation payments, I HEREBY AUTHORIZE release of Social Security Benefit information. (A photocopy can be used in place of original.) This authorization is valid for a period of 12 months from the date signed by employee.

I HAVE REVIEWED, UNDERSTAND, AND ACKNOWLEDGE THE INFORMATION IN THIS SECTION.

Employee's Signature	Employee's Date of Birth: (Month-Day-Year)	Date Signed by Employee: (Month-Day-Year)
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III. SOCIAL SECURITY INFORMATION (To be completed by Social Security Administration)

1. Has this employee applied for Disability Benefits under 42 U.S.C. Section 423? Yes If "YES", date applied
 No ____ / ____ / ____

2. Has the amount payable under 42 U.S.C. Section 423 or 402 been determined and benefits commenced? Yes Denied Pending

3. (a) What was the **INITIAL** benefit paid to the employee (P.I.A.)? \$ _____
DO NOT INCLUDE SUBSEQUENT COST OF LIVING INCREASES

(b) Provide the amount of **INITIAL** Maximum Family Benefits. \$ _____
DO NOT INCLUDE SUBSEQUENT COST OF LIVING INCREASES

(c) What is 80% of Average Current Earnings used to determine benefits (A.C.E.)? \$ _____

(d) What is the number of auxiliaries or dependents in current month? _____

4. Has any offset pursuant to 42 U.S.C. Section 424 been taken? Yes No

5. If "YES" to Question #4 above, list amount of offset. \$ _____

6. If "YES" to Question #4 above, list the date SSA Offset will end. (MM/YY) _____

7. Is employee insured for Social Security Retirement Benefits under 42 U.S.C. Section 402 and 405? Yes No

SSA REPRESENTATIVE SIGNATURE _____ DATE: (Month-Day-Year)

IV. RETURN TO (To be completed by requesting party)

Signature of Requesting Party	Requestor's Address & Telephone
Title of Requesting Party	

Any person who, knowingly and with intent to injure, defraud, or deceive any employer or employee, insurance company, or self-insured program, files a statement of claim containing any false or misleading information commits insurance fraud, punishable as provided in s. 817.234, Section 440.105(7), F.S.

DWC-14 Purpose and Use Statement

The collection of the social security number on this form is imperative for the Division of Workers' Compensation's performance of its duties and responsibilities as prescribed by law. The social security number will be used as a unique identifier in Division of Workers' Compensation database systems for individuals who have claimed benefits under Chapter 440, Florida Statutes. It will also be used to identify information and documents in those database systems regarding individuals who have claimed benefits under Chapter 440, Florida Statutes, for internal agency tracking purposes and for purposes of responding to both public records requests and subpoenas that require production of specified documents. The social security number may also be used for any other purpose specifically required or authorized by state or federal law.