

Authorization for the Social Security Administration (SSA) To Release Social Security Number (SSN) Verification

Printed Name:	Date of Birth:	Social Security Number:
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Reason for authorizing consent: (Please select one)

- | | | |
|---|---|--|
| <input type="checkbox"/> To apply for a mortgage | <input type="checkbox"/> To apply for a loan | <input type="checkbox"/> To meet a licensing requirement |
| <input type="checkbox"/> To open a bank account | <input type="checkbox"/> To open a retirement account | <input checked="" type="checkbox"/> Other |
| <input type="checkbox"/> To apply for a credit card | <input type="checkbox"/> To apply for a job | <u>Employment Related</u> |

With the following company ("the Company"):

Company Name: Security Services of CT, Inc.

Company Address: 25 Controls Drive, Shelton, CT 06484

The name and address of the Company's Agent (if applicable):

Agent's Name: Accio Data

Agent's Address: P.O. Box 787, Dripping Springs, TX 78620

I authorize the Social Security Administration to verify my name and SSN to the Company and/or the Company's Agent, if applicable, for the purpose I identified. I am the individual to whom the Social Security number was issued or the parent or legal guardian of a minor, or the legal guardian of a legally incompetent adult. I declare and affirm under the penalty of perjury that the information contained herein is true and correct. I acknowledge that if I make any representation that I know is false to obtain information from Social Security records, I could be found guilty of a misdemeanor and fined up to \$5,000.

This consent is valid only for one-time use. This consent is valid only for 90 days from the date signed, unless indicated otherwise by the individual named above. If you wish to change this timeframe, fill in the following:

This consent is valid for _____ days from the date signed. _____ (Please initial.)

Signature:	Date Signed:
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Relationship (if not the individual to whom the SSN was issued):

Privacy Act Statement Collection and Use of Personal Information

Sections 205(a) and 1106 of the Social Security Act, as amended, allow us to collect this information. Furnishing us this information is voluntary. However, failing to provide all or part of the information may prevent us from releasing information to a designated company or company's agent. We will use the information to verify your name and Social Security number (SSN). We may also share your information for the following purposes, called routine uses: - To contractors and other Federal agencies, as necessary, to assist us in efficiently administering our programs; and - To student volunteers, persons working under a personal services contract, and others, when they need access to information in our records in order to perform their assigned agency duties. 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 routine uses is available in our Privacy Act System of Records Notice (SORN) 60-0058, entitled Master Files of SSN Holders and SSN Applications, as published in the Federal Register (FR) on December 29, 2010, at 75 FR 82121. Additional information, and a full listing of all our SORNs, is available on our website at www.saa.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 20 minutes 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. .

-----TEAR OFF-----

NOTICE TO NUMBER HOLDER

The Company and/or its Agent have entered into an agreement with SSA that, among other things, includes restrictions on the further use and disclosure of SSA's verification of your SSN. To view a copy of the entire model agreement, visit <http://www.ssa.gov/cbsv/docs/SampleUserAgreement.pdf>.

SAMPLE INSTRUCTIONS SHEET

DO NOT USE SAMPLE

Authorization for the Social Security Administration (SSA)

NAME, DOB and SSN Sections ONLY Can Be Typed or Hand Written (must be legible)

Printed Name: First and Last Name AS IT APPEARS ON CURRENT SSN CARD	Date of Birth: MM/DD/YYYY	Social Security Number: Full SSN
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Reason for authorizing consent: (Please select one)

- | | | |
|---|---|---|
| <input type="checkbox"/> To apply for a mortgage | <input type="checkbox"/> To apply for a loan | Pre-Filled <input type="checkbox"/> To meet a licensing requirement |
| <input type="checkbox"/> To open a bank account | <input type="checkbox"/> To open a retirement account | DO NOT <input checked="" type="checkbox"/> Other |
| <input type="checkbox"/> To apply for a credit card | <input type="checkbox"/> To apply for a job | CHANGE Employment Related |

With the following company ("the Company"):

Company Name: Security Services of CT, Inc.	Pre-Filled
Company Address: 25 Controls Drive, Shelton, CT 06484	DO NOT
	CHANGE

The name and address of the Company's Agent (if applicable):

Agent's Name: Accio Data	Pre-Filled
Agent's Address: P.O. Box 787, Dripping Springs, TX 78620	DO NOT
	CHANGE

I authorize the Social Security Administration to verify my name and SSN to the Company and/or the Company's Agent, if applicable, for the purpose I identified. I am the individual to whom the Social Security number was issued or the parent or legal guardian of a minor, or the legal guardian of a legally incompetent adult. I declare and affirm under the penalty of perjury that the information contained herein is true and correct. I acknowledge that if I make any representation that I know is false to obtain information from Social Security records, I could be found guilty of a misdemeanor and fined up to \$5,000.

This consent is valid only for one-time use. This consent is valid only for 90 days from the date signed, unless indicated otherwise by the individual named above. If you wish to change this timeframe, fill in the following:

This consent is valid for _____ days from the date signed. _____ (Please initial.)

Signature: WET SIGNATURE BY HAND ONLY (ELECTRONIC IN ANY FORMAT NOT PERMITTED) Date Signed: CURRENT DATE MM/DD/YYYY

Relationship (if not the individual to whom the SSN was issued):

Privacy Act Statement Collection and Use of Personal Information

Sections 205(a) and 1106 of the Social Security Act, as amended, allow us to collect this information. Furnishing us this

SSA-89 FORMAT REQUIREMENTS

1. Any corrections/cross-outs must be initialed by you.
2. DO NOT REMOVE the "TEAR OFF" SECTION BELOW, leave the form intact.
3. All text of the form including margins, header, and footer must be visible and legible in upload.
(Your form will be rejected if any information is cut off or illegible)
4. DO NOT EMAIL THE COMPLETED FORM. A secure, direct upload portal is available to you.
(You can scan, take a photo with your mobile device, or use an application like Cam Scanner to obtain a clear file of your completed SSA-89 Form for submission)
5. If you cannot upload the completed form directly to your applicant portal, contact UConn Human Resources for alternatives.

-----TEAR OFF-----

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SAMPLE FORM - DO NOT USE