SOCIAL SECURITY INFORMATION REQUEST

Department of Workforce Development
Worker's Compensation Division
201 E. Washington Ave., Rm. C100
P.O. Box 7901
Madison, WI 53707
Imaging Server Fax: (608) 260-2503
Telephone: (608) 266-1340
Fax: (608) 267-0394
https://dwd.wisconsin.gov/wc
e-mail: DWDDWC@dwd.wisconsin.gov

*Provision of your Social Security Number (SSN) is voluntary. Failure to provide it may result in an information processing delay.
The Department of Workforce Development (DWD) administers the Worker's Compensation Act, Chapter 102 Wis. Stats. The purpose of this form is to assist with the procurement of information related to or required by Chapter 102. Completion of this form is voluntary and failure to complete said form may result in a delay in the administration of Chapter 102. DWD may use the personally identifiable information (PII) it obtains from you on this form for purposes other than those for which it is being collected.

See Reverse Side for Instructions

1. WC Claim Number		2. Employee Name
3. Social Security Number*	4. Date of Birth	5. Employee Mailing Address (number, street, city, state, zip code)
6. Injury Date		

Social Security Release Authority (To be completed by employee)

I authorize the Social Security Administration to release the information requested below to:

7. Insurance Company Representative or Self-Insured Employer Name	8. Mailing Address (number, street, city, state, zip code)

I understand that the information requested is for computing the amount of worker's compensation payments for which I would be entitled. The information below is not to be disclosed to others or to be used for other purposes without my additional consent.

This authorization shall remain in effect for one year from the date below or until revoked by me in writing if earlier.

9. Signature (do not print)	10. Date Signed	11. Social Security Number (only if different from above)

Office Use Only

Social Security Disability Benefit Information

12. Status of Disability Claim

☐ Approved ☐ Denied ☐ Pending ☐ No Claim Filed

13. 80% of Monthly Average Current Earnings (ACE) $

14. Disability MBA for W/E at Initial Entitlement $

15. Month and Year of Entitlement

16. Month and Year of Last Disability Check if Terminated

17. SSA Representative Signature	18. Date Signed
19. Office Location	20. Telephone Number

SSA INSTRUCTIONS

Insurance Company or Self Insured Employer

1. Enter WC claim number
2. Enter employee's name
3. Enter employee's social security number
4. Date of Birth
5. Enter employee's address
6. Enter injury date
7. Enter your name
8. Enter your mailing address

- Send this form to the employee

Employee

9. Provide your signature, do not print
10. Enter date of your signature
11. Enter your social security number **only** if it is different from the number in "3."

- **Important Notice**: Return this form to the address in "7." within 30 days. If you do not sign this form, your insurance carrier or employer can reduce your benefits by 75%. When you sign, any benefits that were withheld will be paid to you.

Insurance Company or Self Insured Employer

- Once you receive this form from the employee, send the signed form to the SSA district office that handles this employee.

Social Security Administration

- See TN 11 2-83 D100203.050
  If any of the information below is not available, forward this form to Baltimore. The insurance carrier needs all this information, except Line 15, to compute a reverse offset.

  If the claim is currently being reviewed but payments were made in the past, please follow the instructions for 11 through 18:

12. Enter status of the disability claim
13. Enter 80% of ACE
14. Enter MBA
15. Enter month and year of entitlement
16. Enter month and year of last disability check (only if benefits are ending)
17. Attain Social Security Administration representative's signature
18. Enter date of Social Security Administration representative's signature
19. Enter city
20. Enter telephone number of Social Security Administration representative for possible questions from insurance carrier

- Send this completed form to the address in "7."

Insurance Company or Self Insured Employer

- Fill out a *Social Security Reverse Offset Worksheet*. If you find that you can take an offset, send copies of this form and the Worksheet to:

  Worker's Compensation Division
  P.O. Box 7901
  Madison, WI 53707

- The employee and Social Security Administration representative must sign this form or Reverse Offset will not be computed. Computerized forms from the Social Security Administration will not be accepted.