

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

Printed Name:	Date of Birth:	Social Security Number:
---------------	----------------	-------------------------

Reason for authorizing consent: (Please select one)

- |   |   |  |
|---|---|--|
| <input checked="" 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 type="checkbox"/> Other                           |
| <input type="checkbox"/> To apply for a credit card         | <input type="checkbox"/> To apply for a job           |  |

With the following company ("the Company"):

Company Name: FLORIDA CAPITAL BANK, N.A.

Company Address: 10151 DEERWOOD PARK BLVD., BLDG 100 STE 200, JACKSONVILLE, FL 32256

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

Agent's Name: AUTOMATION RESEARCH, INC. (D/B/A DATAVERIFY)

Agent's Address: 250 E. BROAD ST., STE 2100, COLUMBUS, OH 43215

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:
------------	--------------

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](http://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>.