

IN THE COURT OF COMMON PLEAS OF PHILADELPHIA COUNTY
FIRST JUDICIAL DISTRICT OF PENNSYLVANIA

IN RE: FIREFIGHTER HEARING LOSS : TRIAL DIVISION – CIVIL
LITIGATION :

JUNE TERM, 2008

NO. 3755

DOCKETED
COMPLEX LIT CENTER

DEC 8 2008

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PURSUANT TO Pa.R.C.P. 236(b)

DEC 8 2008

FIRST JUDICIAL DISTRICT OF PA
USER I.D.: 2

CASE MANAGEMENT ORDER NO. 1
FOR "FIREFIGHTER HEARING LOSS MASS
TORT LITIGATION PROGRAM"

J. STEWART

It is the goal of this Court to secure the just, speedy and inexpensive determination of each "Firefighter Hearing Loss" (henceforth "FF HL") individual personal injury case now pending or hereafter filed in the Court of Common Pleas, Philadelphia County, Pennsylvania and to eliminate duplication of effort, prevent unnecessary paperwork and promote judicial economy.

In order to achieve these objectives, the following Case Management Order No. 1 ("CMO #1") is entered this 3rd day of December 2008, for all individual personal injury "FF HL" cases which are presently pending or are hereafter filed in the Philadelphia County Court of Common Pleas. The coordinated procedures set forth in this Order are without prejudice to any party's right to seek severance or to contest further coordination or consolidation of these actions.

I. MASTER "FF HL" DOCKET

The Court has established a Master "FF HL" Docket at June Term, 2008, No.3755. This docket number has been established as a depository for the filing of pleadings, motions, orders and other documents common to individual "FF HL" personal injury cases. Once a pleading, motion, order or other document is filed in this docket and copies are produced to all other interested counsel involved in the "FF HL" litigation, the pleading, motion and order or other

In Re: Firefighters Hearing Loss Program-ORDER



document may be incorporated by reference either orally before the Court or within another properly filed pleading, motion, order or other document.

II. PLEADINGS

A. MASTER LONG FORM COMPLAINT

1. In a previously-filed case, Dejewski v. Federal Signal Corporation (Prior Docket No.: September Term 2007, No. 2282), Plaintiffs filed a mutually-acceptable Master Long Form Complaint (“MLFC”), in the form of an Amended Complaint which was filed on December 14, 2007, and which has already been served upon defendant, Federal Signal Corporation (“FSC”).

2. FSC has already filed, in the above-referenced Dejewski case, a mutually-acceptable Master Long Form Answer (“MLFA”), in the form of an Answer to the Amended Complaint which was filed on April 25, 2008, and which has already been served upon plaintiffs’ counsel.

3. The Dejewski “MLFC” and “MLFA” shall serve as the standard long-form pleadings for all existing and newly-filed cases in the “FF HL” litigation.

4. Any plaintiff who wishes to file a claim against a new defendant not named in the existing MLFC, must simultaneously serve a copy of this Order and the MLFC on any such defendant. Failure to do so will relieve a defendant not named in the MLFC of the obligation to answer or preliminarily object to the MLFC.

5. Subject to Paragraph No. 4 above, subsequently added defendants shall have the right to file an Answer or Preliminary Objections to the MLFC within thirty (30) days of actual valid service of a Writ of Summons or Short Form Complaint of an individual “FF HL”

case pending in the Philadelphia County Court of Common Pleas. Plaintiffs shall then have thirty (30) days to respond to the subsequently added defendants' preliminary objections.

6. The Court will rule on the preliminary objections and whether a hearing thereon will be held is subject to the sole discretion of the Court. The Court's ruling on the preliminary objections will be binding for all current and future personal injury individual "FF HL" cases filed in Philadelphia County.

7. If preliminary objections are sustained to one or more counts in the MLFC, plaintiffs, if so ordered, shall file a conforming Amended Master Complaint within thirty (30) days of the Order sustaining the preliminary objections.

8. If preliminary objections are sustained to one or more counts in the Master Complaint, those counts are deemed stricken from the Short Form Complaint.

9. In the event that an Amended MLFC is filed, defendants shall have thirty (30) days from the filing of the Amended MLFC to file a responsive pleading; or, if no Amended MLFC need be filed, any new defendant shall have thirty (30) days from the Order denying preliminary objections to file a MLFA.

10. If New Matter is pleaded, such New Matter will be deemed denied and plaintiffs are not required to file any further responsive pleadings to defendant's New Matter. Further, any previously-pleaded New Matter filed by defendant which has not been answered to date, shall be deemed denied by plaintiffs.

B. PLAINTIFFS' SHORT-FORM COMPLAINT

1. For all newly-filed cases (filed after the date of this "FF HL" CMO #1), individual short-form complaints shall be filed for each plaintiff. Each short-form complaint ("SFC") shall include the information required by paragraph 2 below and shall be verified in

accordance with Pa. R. Civ. P. 1024. If more than one defendant is named in the SFC, the specific defendants against whom claims are alleged shall be specifically identified in the SFC for that plaintiff.

2. Each short-form complaint shall state:
 - a. Plaintiff's name and address;
 - b. Plaintiff's date of birth;
 - c. Plaintiff's social security number;
 - d. A list of plaintiff's Philadelphia Fire Department work sites and the approximate dates of plaintiff's employment at each site;
 - e. The names and addresses of plaintiff's diagnosing physicians; and
 - f. The date(s) of diagnosis of plaintiff's alleged hearing loss injury. A copy of any available audiogram(s) in plaintiff's possession must be attached to plaintiff's FSC.
3. Each SFC shall also have attached to it a completed Plaintiff's Fact Sheet, in the form attached as Exhibit A to this CMO No. 1.

C. ANSWERS AND ENTRY OF APPEARANCE

1. Within 30 days of service of plaintiff's SFC, individual defendants shall separately file entries of appearance, identifying by plaintiff name and case number, each case in which the defendant is named. The entries of appearance shall include counsel's e-mail address. Each entry of appearance shall automatically constitute:

- a. a denial of all averments of fact in the plaintiffs' Complaint;
- b. an allegation of all available affirmative defenses;
- c. an assertion of crossclaims for indemnification and/or contribution against all other defendants in the action; and

d. a denial of all crossclaims asserted against the filing defendant and an assertion of all available affirmative defenses to claims for indemnification and contribution.

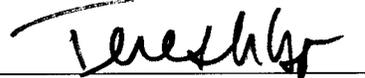
e. a perfected Demand for Jury Trial

2. Any entries of appearance filed by defendant prior to entry of this “FF HL” CMO #1 shall not bar or waive the rights of that defendant to file and/or join Preliminary Objections. Any defendant who previously filed entries of appearance is not required to re-file its entries of appearance, and any previously-filed entries of appearance shall be deemed to incorporate the terms set forth in a-e above.

D. AMENDED COMPLAINTS

Any defendant which is named as party in an original complaint need not serve or file a responsive pleading to any amended complaint. If an amended complaint raises additional claims or sets forth new, substantive allegations, a defendant may serve and file a response within the time prescribed by the Pennsylvania Rules of Civil Procedure. If a defendant chooses not to respond to an amended complaint, its previously-filed appearance or answer shall be deemed to incorporate the terms set forth in II. C. 1. a-e above, as its answer to the amended complaint, and any New Matter contained therein shall be deemed denied by plaintiff.

BY THE COURT:



Allan L. Tereshko, J.
Coordinating Judge
Complex Litigation Center

Dated: _____

**IN THE COURT OF COMMON PLEAS OF PHILADELPHIA COUNTY
FIRST JUDICIAL DISTRICT OF PENNSYLVANIA**

IN RE: FIREFIGHTER HEARING LOSS : TRIAL DIVISION – CIVIL
LITIGATION :
: JUNE TERM, 2008
:
: NO. 3755

PLAINTIFF'S FACT SHEET

A. PERSONAL INFORMATION

1. Full Name (First, Middle and Last): _____
2. Nicknames, Aliases or other names used or by which you have been known, and the dates during which you were known by such names: _____
3. Identify each address at which you have resided during the last ten years, including time periods of residence, beginning with your current address first.

[Attach additional sheets if necessary.]

4. Social Security Number: _____ Driver's License Number: _____
5. Date and Place of Birth: _____

6. List your educational history (from high school forward, including each school, college, university or other education institution you have attended, the dates of your attendance, courses of study and diplomas or degrees obtained):

[Attach additional sheets if necessary.]

7. List any military experience, and if so, provide:
 - a. Branch: _____
 - b. Years of Service: _____
 - c. Occupational assignment: _____
 - d. Veteran's I.D. Number: _____
 - e. Form of discharge: _____

- f. Execute attached Department of Veterans Affairs forms entitled: 1) **REQUEST FOR AND AUTHORIZATION TO RELEASE MEDICAL RECORDS OR HEALTH INFORMATION**" (Exhibit A) and 2) **"REQUEST FOR AND CONSENT TO RELEASE OF INFORMATION FROM INDIVIDUAL'S RECORDS"** (Exhibit B).

8. PFD Employment – state years of service (from when to when) and current job title:

9. Execute attached 1) **"HIPAA COMPLIANT AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH/MEDICAL INFORMATION TO AN ATTORNEY/LAW FIRM"** (Exhibit C) and 2) **"AUTHORIZATION FOR RELEASE OF EMPLOYMENT RECORDS"** (Exhibit D):

10. SSA Records: Execute attached **"REQUEST FOR SOCIAL SECURITY EARNINGS INFORMATION"** (Exhibit E).

B. CLAIMS/LAWSUITS

1. Have you ever filed any claim or lawsuit (including workers' compensation claim and/or social security disability) in which you alleged that you had suffered hearing loss?

2. If yes to the above please state:

- a. Year claim was filed: _____
b. Where claim was filed: _____
c. Court/docket number (if applicable): _____

C. FIREFIGHTER EXPERIENCE

1. Have you ever been a member of a union while with the PFD?

Yes: _____ No: _____

If yes, please state:

- a. If your membership is active: _____
b. When you joined: _____
c. Any titles or positions you have held: _____
d. Any committees you have served upon: _____

D. HEARING LOSS

1. Attach copy of all reports of audiograms in your possession.

2. Have you ever been diagnosed with any of the following?

- a. Scarlet fever: Yes: _____ No: _____
- b. Mumps: Yes: _____ No: _____
- c. Measles: Yes: _____ No: _____
- d. Pertussis (whooping cough): Yes: _____ No: _____
- e. Chicken pox: Yes: _____ No: _____
- f. Influenza: Yes: _____ No: _____
- g. Pneumonia (viral or bacterial): Yes: _____ No: _____
- h. Typhoid fever, diphtheria, syphilis: Yes: _____ No: _____
- i. High fever: Yes: _____ No: _____
- j. Otitis externa (infection in outer ear, e.g., swimmer's ear): Yes: _____ No: _____
- k. Otitis media (middle ear infection): Yes: _____ No: _____
- l. Mastoiditis (inflammation behind ear on / by mastoid) Yes: _____ No: _____
- m. Mastoidectomy (surgery for mastoiditis): Yes: _____ No: _____
- n. Meningitis (viral or bacterial): Yes: _____ No: _____
- o. Encephalitis (viral or bacterial – inflammation of the brain): Yes: _____ No: _____
- p. Tumorous growths, cancer: Yes: _____ No: _____
- q. Circulatory disease: Yes: _____ No: _____
- r. Adenoid hypertrophy (excessive growth in the adenoid tonsil): Yes: _____ No: _____
- s. Diabetes: Yes: _____ No: _____
- t. Atherosclerosis (hardening of the arteries): Yes: _____ No: _____
- u. Hypertension (high blood pressure): Yes: _____ No: _____
- v. Otosclerosis (degenerative condition of the temporal bone): Yes: _____ No: _____
- w. Meniere's Disease (an inner ear disorder): Yes: _____ No: _____
- x. Autoimmune disease: Yes: _____ No: _____
- y. Allergies: Yes: _____ No: _____

VERIFICATION

I, _____, have read the foregoing Plaintiff's Fact Sheet, and the facts set forth therein are true and correct to the best of my knowledge, information and belief. I understand that the statements made herein are made subject to the penalties of 18 Pa.C.S. § 4904 relating to unsworn falsification to authorities.

Dated: _____



Department of Veterans Affairs

REQUEST FOR AND CONSENT TO RELEASE OF INFORMATION FROM INDIVIDUAL'S RECORDS

PRIVACY ACT STATEMENT: The execution of this form does not authorize the release of information other than that specifically described below. The information requested on this form is solicited under Title 38, United States Code, and will authorize release of the information you specify. The information may also be disclosed outside VA as permitted by law to include disclosure as stated in the "Notices of Systems of VA Records" published in the Federal Register in accordance with the Privacy Act of 1974.

RESPONDENT BURDEN: VA may not conduct or sponsor, and the respondent is not required to respond, to this collection of information unless it displays a valid OMB Control Number. The Privacy Act of 1974 (5 U.S.C. 552a) and VA's confidentiality statute (38 U.S.C. 5701) as implemented by 38 CFR 1.526(a) and 38 CFR 1.576(b) require individuals to provide written consent before documents or information can be disclosed to third parties not allowed to receive records or information under any other provision of law. The information requested is approved under OMB Control Number 2900-0028 and is necessary to ensure that the statutory requirements of the Privacy Act and VA's confidentiality statute are met.

Responding to this collection of information is voluntary. However, if the information is not furnished, we may not be able to comply with your request. Public reporting burden for this collection is estimated to average 7.5 minutes per respondent, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspects of this collection of Information, including suggestions for reducing this burden, to the VA Clearance Officer (005E3), 810 Vermont Avenue, NW, Washington, DC 20420. Send comments only. Do not send this form or requests for benefits to this address.

TO	Department of Veterans Affairs	NAME OF INDIVIDUAL (Type or print)	
		VA FILE NO. (include prefix)	SOCIAL SECURITY NUMBER

NAME AND ADDRESS OF ORGANIZATION OR INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

VETERAN'S REQUEST

I hereby request and authorize the Department of Veterans Affairs to release the following information from the records identified above to the organization, agency, or individual named hereon:	NAME
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INFORMATION REQUESTED (Number each item requested and give the dates or approximate dates - period from and to - covered by each.)

PURPOSE(S) FOR WHICH THE INFORMATION IS TO BE USED.

NOTE: Additional information may be listed on the reverse side of this form.

SIGNATURE OF INDIVIDUAL OR PERSON AUTHORIZED TO SIGN FOR INDIVIDUAL (Attach authority to sign, e.g., POA)	DATE
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**HIPAA COMPLIANT AUTHORIZATION FOR USE/DISCLOSURE
OF PROTECTED HEALTH/MEDICAL INFORMATION TO AN
ATTORNEY/LAW FIRM**

1.) **To:** _____ (collectively "you")

(Insert Name of Covered Entity, i.e., Physician, Hospital, Healthcare Facility, Etc.)

2.) **Patient Name:** _____

3.) **Date of Service:** Any and all service provided.

4.) Authorization to Disclose PHI Pursuant to the Health Insurance Portability and Accountability Act ("HIPAA"):

This is to authorize and instruct you to furnish to: Wayne A. Graver, Esquire

(Insert name of attorney(s) or firm(s) authorized to receive the information)

the following specific medical records constituting protected health information (or "PHI" as that term is defined by HIPAA, including any regulations enacted pursuant thereto), including opinions, reports, x-rays, ultrasound records, or any other records, information or documents that you may have in your custody or under your control regarding the patient whose name appears above: ALL

(Specify the PHI that may be disclosed pursuant to this authorization, or check below to release ALL PHI held by the CE)

If psychiatric records, HIV/AIDS information, substance abuse information, tuberculosis information, genetic information and/or sexually transmitted disease information is included in these records, initial next to the appropriate line below in order to include such records in this release:

<input type="checkbox"/> HIV/AIDS Related Information	<input type="checkbox"/> Mental Health and Psychotherapy Information
<input type="checkbox"/> Genetic Information	<input type="checkbox"/> Sexually Transmitted Disease Information
<input type="checkbox"/> Drug and Alcohol information	<input type="checkbox"/> Tuberculosis Information

NOTE: If this section is left blank, authorization to release psychiatric records, HIV/AIDS records and substance abuse records will be presumed to be DENIED.

The purpose for this request is: Ongoing litigation

I acknowledge that this information may be redisclosed by the person(s) to whom it is disclosed pursuant to this authorization, and/or others. If so redisclosed, the information may no longer be protected by law. The privilege I have to maintain the confidentiality of this PHI is not waived for any other organizations, individual or insurance company not named herein. By affixing my signature below, I acknowledge that I waive all liability whatsoever for any person who cooperates with this request to release medical records. A photocopy of this release may be used in place of the original. This release expires upon the earlier of its first use by the disclosure recipient named herein, or six (6) months from the date below. I understand that I may receive treatment from any healthcare providers mentioned in this release without executing this release. Further, I understand that this release may be revoked in writing by me. However, any actions taken by any party in reliance upon this release, taken before the written revocation is received by that party won't be affected by the revocation.

Print Name: _____ Patient ID#: _____
(Number Used by CE to Identify Patient)

Signature: _____ Dated: _____ / _____ / _____

If Patient's personal representative, describe

Relationship to patient: _____

AUTHORIZATION FOR RELEASE OF EMPLOYMENT RECORDS

NAME OF PLAINTIFF

SSN:

DOB:

Employer: NAME/ADDRESS

TO WHOM IT MAY CONCERN:

Please be advised that the undersigned hereby authorized the release of any and all employment information in your possession, custody and control, including, but not limited to, any and all records, documents, statements, medical records, medical reports, health examinations, hospital records or reports, physicians' records or reports, medical provider records or reports, payroll records, attendance reports or logs, workers' compensation records, workers' compensation claims information, photographs or information of any kind relating to the employment of _____ during all periods of employment with your company, and to permit the originals of all such records to be examined, photographed and/or copied.

This shall constitute sufficient power of attorney for obtaining such information, records, reports, etc., for release to Wayne A. Graver, Esquire, Lavin, O'Neill, Ricci, Cedrone & DiSipio 190 North Independence Mall West, Suite 500, 6th & Race Streets, Philadelphia, PA 19106.

NAME OF PLAINTIFF

REQUEST FOR SOCIAL SECURITY EARNINGS INFORMATION

*Use This Form If You Need

1. Certified/Non-Certified Detailed Earnings Information

Includes periods of employment or self-employment and the names and addresses of employers.

OR

2. Certified Yearly Totals of Earnings

Includes total earnings for each year but does not include the names and addresses of employers.

DO NOT USE THIS FORM FOR:

Non-certified yearly totals of earnings

This service is free to the public.

These totals can be obtained by calling
1-800-772-1213 to receive Form SSA-7004,
Request for Earnings and Benefit Estimate
Statement.

PRIVACY ACT NOTICE: We are authorized to collect this information under section 205 of the Social Security Act, and the Federal Records Act of 1950 (64 Stat. 583). It is needed so we can identify your records and prepare the statement you request. You do not have to furnish the information, but failure to do so may prevent your request from being processed.

PAPERWORK REDUCTION ACT: This information collection meets the clearance requirements of 44 U.S.C. §3507, as amended by Section 2 of the Paperwork Reduction Act of 1995. You are not required to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take you about 11 minutes to read the instructions, gather the necessary facts, and answer the questions.

INFORMATION ABOUT YOUR REQUEST

• **How Do I Get This Information?**

You need to complete the attached form to tell us what information you want.

• **Can I Get This Information For Someone Else?**

Yes, if you have their written permission. For more information, see page 3.

• **Who Can Sign On Behalf Of The Individual?**

The parent of a minor child, or the legal guardian of an individual who has been declared legally incompetent, may sign if he/she is acting on behalf of the individual.

• **Is There A Fee For This Information?**

1. Certified/Non-Certified Detailed Earnings Information

Yes, we usually charge a fee for detailed information. In most cases, this information is used for purposes NOT directly related to Social Security such as for a private pension plan or personal injury suit. The fee chart on page 3 gives the amount of the charge.

Sometimes, there is no charge for detailed information. If you have reason to believe your earnings are not correct (for example, you have previously received earnings information from us

and it does not agree with your records), we will supply you with more detail for the period in question. Occasionally, earnings amounts are wrong because an employer did not correctly report earnings or earnings are credited to the wrong person. In situations like these, we will send you detailed information, at no charge, so we can correct your record.

Be sure to show the year(s) involved on the request form and explain why you need the information. If you do not tell us why you need the information, we will charge a fee.

We will certify the detailed earnings information for an additional fee of \$15.00. Certification is usually not necessary unless you plan to use the information in court.

2. Certified Yearly Total of Earnings

Yes, there is a fee of \$15 to certify yearly totals of earnings. Certification is usually not necessary unless you plan to use the information in court.

3. Method of Payment

Enclose a check or money order for the entire fee required. Payment can also be made by credit card. To do so, complete page 4 of this form and return it with your request form.

REQUEST FOR SOCIAL SECURITY EARNINGS INFORMATION

1. From whose record do you need the earnings information?

Print the Name, Social Security Number (SSN), and date of birth below.

Name _____ Social Security Number _____
Other Name(s) Used _____ Date of Birth _____
(Include Maiden Name) (Mo/Day/Yr)

2. What kind of information do you need?

- Detailed Earnings Information** For the period(s)/year(s): _____
(If you check this block, tell us below why you need this information.)
- Certified Total Earnings For Each Year.** For the year(s): _____
(Check this box only if you want the information certified. Otherwise, call 1-800-772-1213 to request Form SSA-7004, Request for Earnings and Benefit Estimate Statement)

3. If you owe us a fee for this detailed earnings information, enter the amount due using the chart on page 3 A. \$ _____

Do you want us to certify the information? Yes No

If yes, enter \$15.00 B. \$ _____

ADD the amounts on lines A and B, and enter the TOTAL amount C. \$ _____

- You can pay by CREDIT CARD by completing and returning the form on page 4, or
- Send your CHECK or MONEY ORDER for the amount on line C with the request and make check or money order payable to "Social Security Administration"
- DO NOT SEND CASH.

4. I am the individual to whom the record pertains (or a person who is authorized to sign on behalf of that individual). I understand that any false representation to knowingly and willfully obtain information from Social Security records is punishable by a fine of not more than \$5,000 or one year in prison.

SIGN your name here (Do not print) > _____ Date _____

Daytime Phone Number _____
(Area Code) (Telephone Number)

5. Tell us where you want the information sent. (Please print)

Name _____ Address _____
City, State & Zip Code _____

6. Mail Completed Form(s) To: **Exception:** If using private contractor (e.g., FedEx) to mail form(s), use:

Social Security Administration
Division of Earnings Record Operations
P.O. Box 33003
Baltimore Maryland 21290-3003

Social Security Administration
Division of Earnings Record Operations
300 N. Greene St.
Baltimore Maryland 21290-0300

REQUEST FOR SOCIAL SECURITY EARNINGS INFORMATION

How Much Do I Have to Pay For Detailed Earnings?

1. Count the number of years for which you need detailed earnings information. Be sure to add in both the first and last year requested. However, do not add in the current calendar year since this information is not yet available.
2. Use the chart below to determine the correct fee.

Number of Years Requested	Fee	Number of Years Requested	Fee	Number of Years Requested	Fee
1	\$15.00	15	\$43.75	28	\$64.50
2	17.50	16	45.50	29	66.00
3	20.00	17	47.25	30	67.50
4	22.50	18	49.00	31	68.75
5	25.00	19	50.75	32	70.00
6	27.00	20	52.50	33	71.25
7	29.00	21	54.00	34	72.50
8	31.00	22	55.50	35	73.75
9	33.00	23	57.00	36	75.00
10	35.00	24	58.50	37	76.25
11	36.75	25	60.00	38	77.50
12	38.50	26	61.50	39	78.75
13	40.25	27	63.00	40	80.00
14	42.00				

For Requests Over 40 Years, Please Add 1 Dollar for Each Additional Year.

• **Whose Earnings Can Be Requested**

1. Your Earnings

You can request earnings information from your own record by completing the attached form; we need your handwritten signature. If you sign with an "X", your mark must be witnessed by two disinterested persons who must sign their name and address.

2. Someone Else's Earnings

You can request earnings information from the record of someone else if that person tells us in writing to give the information to you. This writing or "authorization" must be presented to us within 60 days of the date it was signed by that person.

3. A Deceased Person's Earnings

You can request earnings information from the record of a deceased person if you are the legal representative of the estate, a survivor (that is, the spouse, parent, child, divorced spouse of divorced parent), or an individual with a material interest (example-financial) who is an heir at law, next of kin, beneficiary under the will or donee of property of the decedent.

Proof of death must be included with your request. Proof of appointment as representative or proof of your relationship to the deceased must also be included.

YOU CAN MAKE YOUR PAYMENT BY CREDIT CARD

As a convenience, we offer you the option to make your payment by credit card. However, regular credit card rules will apply.
You may also pay by check or money order.

Please fill in all the information below and return this form along with your request to:

Social Security Administration
Division of Earnings Record Operations
P.O. Box 33003
Baltimore Maryland 21290-3003

Exception:

If using private contractor (e.g., FedEx) to mail form(s), use:

Social Security Administration
Division of Earnings Record Operations
300 N. Greene St.
Baltimore Maryland 21290-0300

Note: Please read Paperwork/Privacy Act Notice

CHECK ONE →	<input type="checkbox"/> Visa <input type="checkbox"/> American <input type="checkbox"/> MasterCard <input type="checkbox"/> Discover <input type="checkbox"/> Diners Card
Credit Card Holder's Name → (Enter the name from the credit card)	_____ First Name, Middle Initial, Last Name
Credit Card Holder's Address →	_____ Number & Street _____ City, State, & Zip Code
Daytime Telephone Number →	_____ Area Code Telephone Number
Credit Card Number →	____-____-____-____
Credit Card Expiration Date →	____/____ Month Year
Amount Charged →	_____
Credit Card Holder's Signature →	_____

DO NOT WRITE IN THIS SPACE OFFICE USE ONLY	Authorization	
	Name	Date
	Remittance Control #	

PRIVACY ACT NOTICE

The Social Security Administration (SSA) has authority to collect the information requested on this form under section 205 of the Social Security Act. Giving us this information is voluntary. You do not have to do it. We will need this information only if you choose to make payment by credit card. You do not need to fill out this form if you choose another means of payment (for example, by check or money order).

If you choose the credit card payment option, we will provide the information you give us to the banks handling your credit card account and SSA's account. We may also provide this information to another person or government agency to comply with federal laws requiring the release of information from our records. You can find these and other routine uses of information provided to SSA listed in the Federal Register. If you want more information about this, you may call or write any Social Security Office.