

Request for Verification of Benefits for the Social Security Administration

AS 1831 (Rev. 8/10)

CALSTRS

California State Teachers' Retirement System
P.O. Box 15275, MS 85
Sacramento, CA 95851-0275
800-228-5453
CalSTRS.com

Complete this form to request a Verification of Benefits for the Social Security Administration letter.

Section 1: Benefit Recipient Information

BENEFIT RECIPIENT NAME (LAST, FIRST, INITIAL) CLIENT ID OR SOCIAL SECURITY NUMBER

STREET ADDRESS (APT #) SSA CLAIM NUMBER

CITY STATE ZIP CODE DATE OF BIRTH (MM/DD/YYYY)

() () ()
TELEPHONE NUMBER ALTERNATE NUMBER FAX NUMBER

Section 2: Social Security Administration Information

NAME OF SOCIAL SECURITY REPRESENTATIVE SSA OFFICE

STREET ADDRESS

CITY STATE ZIP CODE

() () ()
TELEPHONE NUMBER ALTERNATE NUMBER FAX NUMBER

Section 3: Letter Details and Mailing

All Verification of Benefits for the Social Security Administration letters include the following:

- Benefit types
- Original benefit amount
- Current benefit amount
- Benefit effective date (benefit entitlement date)
- Effective date of current amount
- Payable date of current amount

CalSTRS does not provide payment history before 2000. CalSTRS benefits are based on employment not covered by Social Security.

Monthly benefit amounts, quarterly supplemental payments and one-time payments for specified date range:

From: _____ To: _____

First eligibility date (select this option only if the first eligibility date is unknown or estimated to be before 1986)

Send letter to:

Social Security Administration only (copy will be mailed to benefit recipient)

By: Fax Mail

Benefit recipient only

By: Fax Mail

If you have questions or need additional information, call CalSTRS at 800-228-5453, e-mail us at CalSTRS.com/contactus, fax us at 916-414-5474, or write to us at P.O. Box 15275 • MS 85 • Sacramento, CA 95851-0275.



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**Request for Verification of Benefits
for the Social Security Administration** continued



Name _____ Client ID or SSN _____

Section 4: Benefit Recipient Authorization

You do not need to complete this section if this request originated from the Social Security Administration.

I certify under penalty of perjury under the laws of the State of California that the foregoing is true and correct.
I understand that perjury is punishable by imprisonment for up to four years (Penal Code section 126).

I authorize CalSTRS to release any information requested by the Social Security Administration regarding benefits paid to me or my dependents.

PRINT NAME OF BENEFIT RECIPIENT

Signature

 _____

BENEFIT RECIPIENT SIGNATURE

DATE (MM/DD/YYYY)