



# Social Security Release

I / We hereby authorize the Social Security Office listed below to release information concerning my / our yearly benefits to the Student Financial Aid Office of University of Medicine and Dentistry of New Jersey.

Location of Social Security Office: \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Student's Name (Please Print) \_\_\_\_\_ Parent's Name (Please Print) \_\_\_\_\_

University Identification Number (UIN) School \_\_\_\_\_ Parent's SSN \_\_\_\_\_

Student's Signature \_\_\_\_\_ Date \_\_\_\_\_ Parent's Signature \_\_\_\_\_ Date \_\_\_\_\_

**STUDENT: COMPLETE ABOVE & RETURN TO THE STUDENT FINANCIAL AID OFFICE**

**TO:** Social Security Office  
**FROM:** UMDNJ Student Financial Aid Office  
**RE:** Yearly Benefits

**PLEASE RETURN TO:**

Please certify the amount of yearly benefits paid to **all** members of the family receiving assistance under the social security number listed above and return this form to our office. List each individual family member and the amount received for the **previous** calendar year. Thank you.

**NAME:**

**TOTAL AMOUNT RECEIVED:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature of Social Security Representative

Name / Title (Please Print)