

Registration for Appointed Representative Services and Direct Payment

Purpose of Form

Complete this form if you:

- want to register for direct payment of fees,
- registered for direct payment of fees prior to 10/31/2009 and need to update your information,
- registered as an appointed representative on or after 10/31/2009 and need to update your information, or
- received a notice from the Social Security Administration instructing you to complete this form.

NOTE: If you are not in the business of providing services to Social Security claimants and beneficiaries, but will be appointed as a representative for a relative, friend, or other acquaintance, **YOU DO NOT NEED TO COMPLETE THIS FORM.**

This form also collects information necessary to conform to Internal Revenue Code sections 6041 and 6045(f), which require us to issue IRS Form 1099-MISC to individuals who represent claimants and receive direct payment of \$600 or more during a tax year.

General Information and Instructions

- Complete this form and fax it to the Office of Central Operations at 1-877-268-3827. **Do not fax more than one Form SSA-1699 at a time.**
- You will receive a notice containing your Representative Identification (Rep ID) once your initial registration is complete. Allow 2 to 3 weeks to receive your notice.
- If you are currently suspended or disqualified from representing claimants in dealings with the Social Security Administration, you may not register until your suspension has ended or we have reinstated you.
- You must update your registration by completing a new form if your personal, professional, or business affiliation information changes including information related to disbarments, suspensions, or sanctions.
- We may return incomplete or inaccurate forms.
- For more information, please call 1-800-772-6270 or visit our website at www.socialsecurity.gov/ar. If you are hearing impaired, call our TTY number at 1-800-325-0778. You may also visit your local Social Security office.

Explanation of Terms for Completing This Form

- **Representative** – an attorney or individual other than an attorney who meets all of our requirements and is appointed to represent claimants in dealings with us.
- **Representative Identification (Rep ID)** – a 10-character ID that we assign. You will use this Rep ID in lieu of your Social Security Number (SSN) if you need to update information on this form.

This sample 1699 shows what you need to complete if you are ONLY signing up for eFolder access and do NOT want direct payment of authorized fees. Use this as a guide when completing the 1699 you received with your mailed invitation. Complete all highlighted sections.

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If you have not yet requested an invitation to enroll with ARS for eFolder Access, contact your local hearing office and request an invitation be mailed to you.

Privacy Act Statement

Collection and Use of Personal Information

Sections 206(a) and 1631(d) of the Social Security Act, as amended, authorize us to collect this information. The information. We will use the information you provide to facilitate direct payment of authorized fees and to meet the reporting requirements of the law.

The information you furnish on this form is voluntary. However, failure to provide the requested information will prevent you from serving as an appointed representative.

We generally use the information you supply for the purpose of facilitating payments. However, we may use it for the administration and integrity of Social Security programs. We may also disclose information to another person or to another agency in accordance with approved routine uses, which include but are not limited to the following:

1. To enable a third party or an agency to assist Social Security in establishing rights to Social Security benefits and/or coverage;
2. To comply with Federal laws requiring the release of information from Social Security records (e.g., to the Government Accountability Office and Department of Veterans' Affairs);
3. To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level; and
4. To facilitate statistical research, audit or investigative activities necessary to ensure the integrity of Social Security programs.

We may also use the information you provide in computer matching programs. Matching programs compare our records with records kept by other Federal, State, or local government agencies. Information from these matching programs can be used to establish or verify a person's eligibility for Federally-funded or administered benefit programs and for repayment of payments or delinquent debts under these programs.

Additional information regarding this form, routine uses of information, and our programs and systems, is available on-line at www.socialsecurity.gov or at your local Social Security office.

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 control number. We estimate that it will take 20 minutes to read the instructions, gather the facts, and answer the questions. You may send **comments on our time estimate**, not the completed form, to SSA, 6401 Security Boulevard, Baltimore, MD, 21235-6401

REGISTRATION FOR APPOINTED REPRESENTATIVE SERVICES AND DIRECT PAYMENT

Complete all sections that apply to you. We will return incomplete or inaccurate forms.

Section I: Your Personal Identification and Home Contact Information

- All fields in this section are required unless indicated as optional. For your protection, we collect your home contact information to check against our records.
- If you need to update information you provided on or after 10/31/09, include your name, Rep ID, and all information that has changed. You must attest, sign, and date the updated form.
- Enter your name in the boxes below exactly as it appears on your Social Security card. If you want to use a different name, contact your local Social Security office to change the name currently in our records. You must either receive a new card or receive confirmation that we processed your name change prior to completing this form.

If you registered as an Appointed Representative on or after 10/31/09 and need to update your information, enter your Rep ID below:

If you have a Rep ID, you may enter it here and skip entering your SSN.

Your First Name

Your Middle Name

Your Last Name

Your Suffix (if any)

Your Date of Birth (MM/DD/YYYY)

Your Social Security Number



Your Home Mailing Address

Street Line 1
Line 2

City

State

ZIP/Postal Code

Country (if outside the U.S.)

Your Daytime Telephone Number

Your Home Fax Number (Optional)

Country/Area Code Phone Number Extension

Country/Area Code Fax Number

Your Email Address (Optional - Used for registration purposes and Social Security online service messages.)

Section II: Your Representational Standing

Check one of the boxes below.

Are you currently in good standing and admitted to practice law before the U.S. Supreme Court; a U.S. Federal, state, territorial, insular possession, or District of Columbia court; or a member of a state bar if that membership carries with it the authority to practice law in that state?

Yes (Go to Section III)

No (Go to Section IV)

You MUST check one of these boxes.
Do not leave this section blank.

NOTE: If you are not in the business of providing services to Social Security claimants and beneficiaries, but will be appointed as a representative for a relative, friend, or other acquaintance, **YOU DO NOT NEED TO COMPLETE THIS FORM.**

Section III: Your Bar and Court Information

Provide information for one state, U.S. territory, or U.S. Federal Court in which you **currently** are in good standing and have the right to practice law.

Court or Bar

Year
Admitted
(YYYY)

Court or Bar License Number
(If one issued)

Complete Section III only if you answered "Yes" to the question in Section II. If you represent claimants as a non-attorney representative, you may still obtain eFolder access.

Section IV: Your Information as a Representative

All representatives must complete this section.

1. **Your Address for Receipt of Notices**

Same as Home Address in Section I

Street Line 1
Line 2

City

State

ZIP/Postal Code

Country(if outside the U.S.)

2. **Business Telephone Number** (if different from that provided in Section I.)

Business Fax Number (Optional)

Country/Area Code Phone Number Extension

Country/Area Code Fax Number

3. **Business Email Address** (Optional)

4. **Did you check "Yes" in Section II OR have you been notified by us that you are eligible for direct payment of your fees?**

Yes

No (Go to Section VI)

5. **What is your preferred payment method?**

Direct Deposit to U.S. Bank – I am the owner or co-owner of this account. (You must be the owner or co-owner)

Type of Financial Account: Checking Savings

Routing Number

Account Number

Write in this section "N/A- Not requesting Direct Pay. eFolder Access only" Do NOT check any boxes or provide direct deposit information.

OR

Check – Will be mailed to the **Notice Address**

6. **Your Tax Address** (This is the address where we will send your FORM 1099-MISC)

Same as Home Address

Same as Notice Address in 1

Do NOT complete this section if you are not requesting direct pay.

Street Line 1
Line 2

City

State

ZIP/Postal Code

Country(if outside the U.S.)

SECTION V: Your Information When You Are Working for a Firm or Organization

Complete this section if your work as a representative will be affiliated with a firm or organization. If you work for more than one firm or organization complete and attach as many copies of this section as needed. You will need an EIN in order to complete this section.

Complete 1 through 5 below.

If you work for a company, you may complete 1 through 4 (optional).

1. Employer Identification Number (EIN)

(See your W-2 or contact the firm or organization to get this number.)

Name of Firm or Organization _____

2. Your Address for Receipt of Notices

Same as home address in Section I

Same as notice address in Section IV

Street Line 1

Line 2

City

State

ZIP/Postal Code

Country (if outside the U.S.)

3. Business Telephone Number

Same as home number in Section I

Same as business number in Section IV

Country/Area Code

Phone Number

Extension

Business Fax Number (Optional)

Country/Area Code

Fax Number

4. Business Email Address (Optional)

5. What is your preferred payment method?

Direct Deposit to U.S. Bank

Same bank information as provided in Section IV

OR

Direct deposit to the account shown below. I am the owner or co-owner of this account. (You must be the owner or co-owner of the account)

Type of Financial Account: Checking Savings

Routing Number

Account Number

OR

Check – Will be mailed to the **Notice Address**

Do NOT complete this section if you are not requesting direct pay.

Section VI: Attestations and Questions for Representation

You **MUST ATTEST** to these statements and complete the following questions.

1. **I understand and will comply with** SSA laws and rules relating to the representation of parties, including the Rules of Conduct and Standards of Responsibility for Representatives.

I will not charge, collect, or retain a fee for representational services that SSA has not approved or that is more than SSA approved, unless a regulatory exclusion applies.

I will not threaten, coerce, intimidate, deceive, or knowingly mislead a claimant or prospective claimant, or beneficiary, regarding benefits or other rights under the Social Security Act.

I will not knowingly make or present, or participate in making or presenting, false or misleading oral or written statements, assertions, or representations about a material fact or law concerning a matter within SSA's jurisdiction.

I am aware that if I fail to comply with any SSA laws and rules relating to representation, I may be suspended or disqualified from practicing as a representative before SSA.

I attest to all of the above.

2. **Have you ever been:**

a. **Suspended or prohibited** from practice before SSA or any other Federal program or agency? **Yes (Explain below.)**
 No

b. **Disbarred or suspended** from a court or bar to which you were previously admitted to practice as an attorney? **Yes (Explain below.)**
 No

c. **Convicted of a violation** under Section 206 or 1631(d) of the Social Security Act? **Yes (Explain below.)**
 No

d. **Disqualified** from representing a claimant as a current or former officer or employee of the United States? **Yes (Explain below.)**
 No

3. **For each Yes answer in 2, provide the information below regarding that event** (Attach copies of this page if you need more space.)

**Federal Program or Agency;
or Court or Bar Name:**

**Bar Number (provide the Bar Number if you
have one AND you answered "Yes" to 2b):**

**Year Admitted (provide the year
if you answered "Yes" to 2b):**

Beginning Date of:

Ending Date: (if ended)

Brief Description of Circumstances:

Section VII: General Attestations

You **MUST ATTEST** to these statements.

I will not divulge any information that SSA has furnished or disclosed about a claim or prospective claim, unless I have the claimant's consent or there is a Federal law or regulation authorizing me to divulge this information.

I have in place reasonable administrative, technical, and physical security safeguards to protect the confidentiality of all personal information I receive from SSA, to avoid its loss, theft, or inadvertent disclosure.

I will not omit or otherwise withhold disclosure of information to SSA that is material to the benefit entitlement or eligibility of claimants or beneficiaries, nor will I cause someone else to do so, if I know or should know, that this would be false or misleading.

I will not use Social Security program words, letters, symbols, branding, or emblems in my advertising or other communications, in a way that conveys the false impression that SSA has approved, endorsed, or authorized me, my communications, or my organization, or that I have some connection with or authorization from SSA.

I will update this registration if my personal, professional or business affiliation information changes, including information related to disbarments, suspensions or sanctions.

I am aware that if I fail to comply with SSA laws and rules, I could be criminally punished by a fine or imprisonment or both, and I could be subject to civil monetary penalties.

I understand that SSA will validate the information I provide.

I attest to all of the above.

Perjury Statement

I agree that a copy of this signed Form SSA-1699 will have the same force and effect as the original.

I declare under penalty of perjury that I have examined all of the information on this application and it is true and correct to the best of my knowledge.

Signature of Person Identified in Section I (You must sign your OWN name.)

Date

