Form 115
Adopted 1/1/97

KENTUCKY
DEPARTMENT OF WORKERS' CLAIMS
SOCIAL SECURITY RELEASE FORM

I, _____, having filed an Application for Resolution of Occupational Disease or Hearing Loss Claim for workers' compensation benefits, do hereby authorize the Social Security Administration to release or disclose the Department of Workers' Claims any information in their possession concerning my benefit or wage earnings.

Signed at _____, Kentucky, this the _____ day of _____, 20_____.

_____
Plaintiff's Signature

_____
Social Security Number

_____
Witness Signature