

**Investment** OR  **Pension** OR  **Annuity Verification**  
 (To be completed by insurance agent)

TO: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

RE: \_\_\_\_\_  
 Name \_\_\_\_\_  
 Social Security Number \_\_\_\_\_

FROM: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Thank you for your prompt response. All information is confidential.  
 Please contact \_\_\_\_\_  
 at (\_\_\_\_) \_\_\_\_\_ if you have any questions.

**PERMISSION FOR RELEASE OF INFORMATION**

**You do not have to sign this form if either the requesting organization or the organization supplying the information is left blank.**  
 Release: I hereby authorize the release of the requested information. Information obtained under this consent is limited to information that is no older than 12 months. There are circumstances, which would require the owner to verify information that is up to 5 years old, which would be authorized by me on a separate consent, attached to a copy of this consent.

\_\_\_\_\_  
 Signature Date

**INSURANCE AGENT / ADMINISTRATOR – PLEASE COMPLETE APPLICABLE SECTIONS**

Type of account:  Fixed  Deferred  Variable  Life  Other \_\_\_\_\_  
 Market Value: \$ \_\_\_\_\_  
 Surrender or Withdrawal Fee: \$ \_\_\_\_\_

Is this person receiving regular payments?  Yes  No

If yes, what is the gross amount? \$ \_\_\_\_\_ per (circle one) Month / Quarter / Other \_\_\_\_\_  
 Date benefits began: \_\_\_\_\_ Effective date of current amount: \$ \_\_\_\_\_  
 Date Required Minimum Distribution began/begins: \_\_\_\_\_ RMD Amount: \$ \_\_\_\_\_  
 Deductions from gross amount for medical insurance premiums: \$ \_\_\_\_\_

If no, does the holder receive dividends/interest income?  Yes  No  Reinvested into account  
 If yes or reinvested into account, what is the interest rate? \_\_\_\_\_%  Fixed  Variable  
*If variable, provide current rate.*

Is the holder able to withdraw the balance of the annuity/account?  Yes  No  
 If yes, what is the amount? \$ \_\_\_\_\_ What is the tax rate? \_\_\_\_\_%  
 What is the tax penalty, if any? \_\_\_\_\_

Is the individual reimbursed for medical costs?  Yes  No

Signature of Agent/Administrator \_\_\_\_\_ Date \_\_\_\_\_  
 Print your name \_\_\_\_\_ Tel. # \_\_\_\_\_  
 Address \_\_\_\_\_  
 \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**PENALTIES FOR MISUSING THIS CONTENT:** Title 18, Section 1001 of the U.S. Code states that a person is guilty of a felony for knowingly and willingly making false or fraudulent statements to any department of the United States Government. HUD and any owner (or any employee of HUD or the owner) may be subject to penalties for unauthorized disclosures or improper uses of information collected based on the consent form. Use of the information collected based on this verification form is restricted to the purposes cited above. Any person who knowingly or willingly requests, obtains, or discloses any information under false pretenses concerning an applicant or participant may be subject to a misdemeanor and fined not more than \$5,000. Any applicant or participant affected by negligent disclosure of information may bring civil action for damages and seek other relief, as may be appropriate, against the officer or employee of HUD or the owner responsible for the unauthorized disclosure or improper use. Penalty provisions for misusing the social security number are contained in the Social Security act at 208 (a) (6), (7) and (8). Violations of these provisions are cited as violations of 42 USC 408 (a), (6), (7) and (8).