SOCIAL SECURITY BOARD

Non-Contributory Pension Standing Order Authorization Form

I, _____, with Social Security # | | | | | | | | | |

PRINT NAME AS IT APPEARS ON THE SOCIAL SECURITY CARD **ENTER ALL 9 DIGITS**

_____ Phone/Cell No: _____

PERMANENT ADDRESS: HOUSE NUMBER AND STREET NAME **CITY / TOWN/ VILLAGE /DISTRICT**

hereby authorize_____ with Social Security # | | | | | | | | | |

PRINT NAME AS IT APPEARS ON THE SOCIAL SECURITY CARD **ENTER ALL 9 DIGITS**

☐ To collect my non-contributory pension payment or ☐ To pick up my approved SSB Heritage ATM Card on my behalf as I am unable to collect it personally. Please select reason: ☐ **A)** 75 years & older or ☐ **B)** Resides in remote area or ☐ **C)** Due to current physical condition (Medical Declaration required).

Signature of Pensioner: _____ **Date:** _____ /_____ / _____

Day Month Year

IF YOU ARE UNABLE TO SIGN THIS FORM YOURSELF, IT MAY BE SIGNED ON YOUR BEHALF BY SOMEONE ELSE WHO SHOULD STATE HE OR SHE HAS DONE SO. THIS SIGNATURE MUST BE VALIDATED BY A JUSTICE OF THE PEACE OR BY A SOCIAL SECURITY BRANCH OFFICER BELOW.

Signature on behalf of Pensioner: _____ **Date:** _____ /_____ / _____

Day Month Year

J.P. or SSB Branch Officer Signature: _____ **Date:** _____/_____/ _____

(If Applicable) **Day Month Year**

Authorized Person

I, _____ of _____

Name of authorized person (**Enter as it appears on Social Security Card)** Permanent Address: **House Number and Street Name** **City /Town/Village/District**

Phone/Cell No: _____ and/or Email Address: _____

- I hereby agree to accept payment of pension on behalf of the above signatory for as long as I remain so authorized or for the life of the Signatory. I commit to immediately informing the Social Security Board of any change in circumstance which renders me legally incapable of continuing to accept such pension for and on behalf of the said signatory.
- I hereby accept the Heritage Non-Contributory ATM card on behalf of the above signatory and commit to immediately informing the Social Security Board of any change in circumstance which renders me legally incapable of continuing to use or access pension payments through the approved card for and on behalf of the said signatory.

Signature: _____ **Date:** _____ /_____ / _____

Day Month Year

Medical Provider Declaration

Name of Medical Practitioner _____

Medical Practitioner Registration Number: _____

Present Physical Condition: _____

Ambulates: ☐ with assistance ☐ without assistance

If assistance is required, please specify: _____

OTHER MEDICAL CONDITIONS: _____

Signature: _____ **Date:** _____ /_____ / _____

Day Month Year

Please note this authority is valid for 6 months only. NCP Authorities are due in June and December of each year. Failure to submit this authority on due dates will affect your entitlement to this pension. **If, for any reason, the authorized person fails to inform the Social Security Board of any change in circumstances affecting his/her ability to continue receiving this pension and continues to accept payment, criminal charges will be instituted forthwith. (Revised May 18, 2020)