

PRE-1957 MILITARY SERVICE -- FEDERAL BENEFIT QUESTIONNAIRE

PRIVACY ACT/PAPERWORK ACT NOTICE: The Social Security Administration is authorized to collect the information on this form under section 217 of the Social Security Act, as amended by 42 U.S.C. 417. The information is needed to establish whether the wage earner's military service may be used to determine entitlement to or the amount of any Social Security benefit payable. Your response to this request is voluntary, however, failure to provide all or part of this information could result in the loss of some benefits or insurance coverage. Although the information on this form is rarely used for any purpose other than stated above, there is a possibility that in the administration of the Social Security programs or in the administration of programs requiring coordination with the Social Security Administration, information maybe disclosed as follows: To the branch of the military you served in, or to the Veterans Administration or other Federal agency as required to determine if the military service may be used for Social Security purposes, to comply with Federal laws which require the release of information from Social Security records, and to facilitate statistical research and audit activities needed to assure the integrity and improvement of the Social Security programs.

See Revised PRA, Attached

The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB control number. We estimate that it will take you about 10 minutes to complete this form. This includes the time it will take to read the instructions, gather the necessary facts and fill out the form.

NAME OF WAGE EARNER (FIRST NAME, MIDDLE INITIAL, LAST NAME)	SOCIAL SECURITY NUMBER
NAME USED IN SERVICE (IF DIFFERENT FROM ABOVE)	SERVICE NUMBER

PART I. MILITARY SERVICE HISTORY -- PRIOR TO 1957

Enter the month, day, and year of any active or reserve military service during the period September 16, 1940 through December 31, 1956. If the service **BEGAN BEFORE OR ENDED AFTER** this period, show the starting or ending date even though it is outside the period.

1.	ACTIVE DUTY -- REGULAR AND ACTIVE RESERVE SERVICE Enter information about REGULAR ACTIVE DUTY of any duration and about RESERVE ACTIVE SERVICE of 90 consecutive days or more while on active duty or active duty for training.			
	(A) BRANCH OF SERVICE	(B) DATE ACTIVE DUTY BEGAN		(C) DATE SEPARATED FROM ACTIVE DUTY
		MONTH	DAY YEAR	MONTH DAY YEAR
				(D) RATE OR RANK
2.	RESERVE SERVICE (OTHER THAN ACTIVE RESERVE DUTY SHOWN ABOVE.)			
	(A) BRANCH OF SERVICE	(B) DATE MEMBERSHIP BEGAN		(C) DATE MEMBERSHIP ENDED
		MONTH	DAY YEAR	MONTH DAY YEAR
				(D) RATE OR RANK

PART II. MILITARY RETIREMENT INFORMATION

3.	(a) <input type="checkbox"/> Not retired (If checked, go on to Part III)
	(b) <input type="checkbox"/> Retired { (If veteran is giving information complete (c) and (d) below. (If survivor of veteran is giving information go on to Part III)
	(c) Basis for retirement (Complete even if not receiving pay) <input type="checkbox"/> Length of service <input type="checkbox"/> Disability <input type="checkbox"/> Reserve service -- Payable at age 60 <input type="checkbox"/> Other _____ <input type="checkbox"/> Basis unknown <small>(PLEASE SPECIFY)</small>
	(d) Did you waive all or part of your retirement pay as a condition to receive veterans' administration disability compensation or to receive "civil service" (Office of Personnel Management) or other Federal agency credit for your military service? <input type="checkbox"/> Yes <input type="checkbox"/> No

PART III. CIVILIAN FEDERAL AGENCY BENEFIT INFORMATION
(Including Veterans Administration)

4. (a) Have you ever been, or do you expect to be, entitled to receive a civilian Federal benefit?
 Yes No (If "no", omit the remaining questions and sign below.)

(b) Please check type of benefit that you are receiving, were receiving, or that you expect to receive.
 Age or length of service Disability
 Survivor Other _____
(PLEASE SPECIFY TYPE)

5. (a) Name of Federal agency that was, is now, or will be paying benefit:
 Office of Personnel Management (Formerly Civil Service Commission)
 Veterans' Administration (Check only if receiving benefits because of waiving all or part of military retirement pay)
 Office of Workers Compensation Programs (Check only if receiving benefits because of waiving all or part of another Federal benefit)
Specify in remarks the agency and the type of benefit waived.
 Other (Specify) _____

(b) Years of civilian Federal employment _____	(c) Date claim filed _____	(d) Federal Benefit claim number _____
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6. MOST RECENT Federal employer:
(a) Name of agency (if different from 5(a) above)

(b) City and State where employed

(c) Date last worked

REMARKS: (You may use this space for any explanations. If you need more space, attach a separate sheet.)

I know that anyone who makes or causes to be made a false statement or representation of material fact in an application or for use in determining a right to payment under the Social Security Act commits a crime punishable under Federal law by fine, imprisonment or both. I affirm that all information I have given in this document is true.

SIGNATURE OF APPLICANT

Signature (First name, middle initial, last name) (Write in ink)	Date (Month, day, year)
SIGN HERE	Telephone Number (include area code)

Mailing Address (Number and street, Apt. No., P.O. Box, or Rural Route)

City and State _____ ZIP Code _____

Witnesses are required ONLY if this application has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the applicant must sign below, giving their full addresses.

1. Signature of Witness	2. Signature of Witness
Address (Number and street, City, State and ZIP Code)	Address (Number and street, City, State and ZIP Code)

The following revised PRA Statement will be inserted into the form at its next scheduled reprinting:

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 about 10 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE.** The office is listed under U. S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213 (TTY 1-800-325-0778). *You may send comments on our time estimate above to: SSA, 6401 Security Blvd, Baltimore, MD 21235-6401. Send only comments relating to our time estimate to this address, not the completed form.*