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if other than the disabled person

Name of person completing this form <i>(Please print)</i>		Date Form Completed <i>(Month, day, year)</i>	
E-Mail Address of person completing this form <i>(optional)</i>			
<i>If the person completing this form is other than the disabled person, please complete the following information.</i>			
Relationship to Disabled Person		Daytime Telephone Number	
Address <i>(Number and street)</i>		City	State Zip Code

This change was approved for the SSA-3368 (0960-0579) on 2/1/08