



SOCIAL SECURITY

Refer to:

Date:

Social Security
Number

Worker's Name:

Telephone:
Area Code:

So that we may determine the above-named person's eligibility for Social Security benefits, please furnish the amount of gross wages earned by the employee in each of the months checked below. If no wages were earned in a month, show "none."

Please note that we need to know the amounts earned for services performed within the calendar month, regardless of the amounts paid. If the employee received cash tips, include the amount in the totals for the month.

We appreciate your cooperation in furnishing this information. An envelope requiring no postage is enclosed for your convenience.

Sincerely yours,

Enclosure



Year

If the amount of wages for each month is the same, enter the monthly amount here. \$ _____

<input type="checkbox"/> January \$ _____	<input type="checkbox"/> April \$ _____	<input type="checkbox"/> July \$ _____	<input type="checkbox"/> October \$ _____
<input type="checkbox"/> February _____	<input type="checkbox"/> May _____	<input type="checkbox"/> August _____	<input type="checkbox"/> November _____
<input type="checkbox"/> March _____	<input type="checkbox"/> June _____	<input type="checkbox"/> September _____	<input type="checkbox"/> December _____

See other side for additional years (check if applicable).

~~PRIVACY ACT NOTICE: This report is authorized by law 20 CFR 404.703. While your response is voluntary, your cooperation is needed to assure that the above named person's wage record is accurate and that a correct determination of eligibility for Social Security benefits is made.~~

~~We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it.~~

~~Explanation about these and other reasons why information you provide is available in Social Security Offices. If you want to learn more about this, contact any Social Security Office.~~

See Revised Privacy Act Notice

~~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 30 to 50 minutes to read the instructions, gather the facts, and answer the questions. SEND THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. To find the nearest office, call 1-800-772-1213. Send only comments on our time estimate above to: SSA, 1338 Annex Building, Baltimore, MD 21235-6401.~~

~~I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge.~~

See Revised Paperwork Reduction Act Statement

EMPLOYER		AREA CODE AND TELEPHONE NO.
SIGNATURE	TITLE	DATE

Year _____

If the amount of wages for each month is the same, enter the monthly amount here. \$ _____

<input type="checkbox"/> January \$ _____	<input type="checkbox"/> April \$ _____	<input type="checkbox"/> July \$ _____	<input type="checkbox"/> October \$ _____
<input type="checkbox"/> February _____	<input type="checkbox"/> May _____	<input type="checkbox"/> August _____	<input type="checkbox"/> November _____
<input type="checkbox"/> March _____	<input type="checkbox"/> June _____	<input type="checkbox"/> September _____	<input type="checkbox"/> December _____

Year _____

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<input type="checkbox"/> March _____	<input type="checkbox"/> June _____	<input type="checkbox"/> September _____	<input type="checkbox"/> December _____

Year _____

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<input type="checkbox"/> February _____	<input type="checkbox"/> May _____	<input type="checkbox"/> August _____	<input type="checkbox"/> November _____
<input type="checkbox"/> March _____	<input type="checkbox"/> June _____	<input type="checkbox"/> September _____	<input type="checkbox"/> December _____

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge.

SIGNATURE _____	TITLE _____	DATE _____
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The following revised Privacy Act Statement will be inserted into the form at its next scheduled reprinting:

Privacy Act Statement

Collection and Use of Personal Information

20 CFR 404.703 authorizes us to collect this information. The information you provide will be used to determine your employee's eligibility for Social Security Benefits.

The information you furnish on this form is voluntary. However, we need your cooperation to assure that the above-named person's wage record is accurate and that we can correctly determine eligibility for Social Security benefits.

We rarely use the information you supply for any purpose other than for determining continued eligibility. However, we may use it for the administration and integrity of Social Security programs. We may also disclose information to another person or to another agency in accordance with approved routine uses, which include but are not limited to the following:

1. To enable a third party or an agency to assist Social Security in establishing rights to Social Security benefits and/or coverage;
2. To comply with Federal laws requiring the release of information from Social Security records (e.g., to the Government Accountability Office and Department of Veterans' Affairs);
3. To make determinations for eligibility in similar health and income maintenance programs at the Federal, state and local level; and
4. To facilitate statistical research, audit or investigative activities necessary to assure the integrity of Social Security programs.

We may also use the information you provide in computer matching programs. Matching programs compare our records with records kept by other Federal, state or local government agencies. Information from these matching programs can be used to establish or verify a person's eligibility for Federally funded or administered benefit programs and for repayment of payments or delinquent debts under these programs.

Additional information regarding this form, routine uses of information, and our programs and systems, is available on-line at www.ssa.gov or at your local Social Security office.

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 40 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.*