

**CERTIFICATE OF ELECTION
FOR REDUCED SPOUSE'S BENEFITS**

(Do not write in this space)

Paperwork/Privacy Act Notice: The authority for collecting the information requested on this form is contained in section 202q(5)(A) of the Social Security Act (42 U.S.C. 402q(5)(A)). Submission of the information requested is voluntary. The purpose for which the information is requested is to determine whether the spouse may be eligible to receive reduced benefits. Failure to provide any or all of the requested information will prevent payment of reduced benefits. Information you furnish on this form may be disclosed by the Social Security Administration to another person or governmental agency only with respect to Social Security programs and to comply with Federal laws requiring the exchange of information between the Social Security Administration and another agency.

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| 1. PRINT NAME OF WAGE EARNER OR SELF-EMPLOYED PERSON <i>(Hereafter called "Worker")</i> | ENTER HIS OR HER SOCIAL SECURITY NUMBER _ _ _ _ _ _ _ _ _ _ _ |
| 2. PRINT YOUR FULL NAME <i>(First name, middle initial, last name)</i> | ENTER YOUR SOCIAL SECURITY NUMBER <i>(If "none" or "unknown" so indicate.)</i> _ _ _ _ _ _ _ _ _ _ _ |

A spouse's insurance benefit may be payable for months between age 62 and full retirement age (FRA), even if you do not have in your care a child of the worker under age 16 or disabled entitled to a child's insurance benefit. However, since such benefit will be at a reduced rate and will continue at a reduced rate even after FRA, the law requires that we obtain a certificate of election if you wish to receive the reduced benefit. The amount of the reduction is 25/36 of 1 percent times the number of months from the start of the reduced benefits to, but not including, the month you reach FRA. In addition, if another beneficiary(ies) other than the wage earner (e.g., a student child beneficiary) is entitled to a monthly benefit on this Social Security number, election for a reduced spouse's benefit may cause a reduction in total monthly benefits. These reduced benefits may be paid for as many as 12 months before the month this certificate is filed. No reduced spouse's benefit may begin before the month you are 62. If you are eligible for retirement insurance benefits in the month this certificate takes effect, you will be considered to have applied for them.

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| 3. | I elect to accept reduced benefits as provided in Section 202(q) of the Social Security Act, beginning with _____ <div style="display: flex; justify-content: space-around; width: 100%;"> <i>(Month)</i> <i>(Year)</i> </div> |
| 4. | Were you in the active military or naval service after September 7, 1939 and before 1968? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. | Did you work in the railroad industry for 5 years or more? <input type="checkbox"/> Yes <input type="checkbox"/> No |

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 OF PERSON COMPLETING THIS CERTIFICATE

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

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

| | | |
|----------------|----------|---|
| City and State | ZIP Code | Enter Name of County (if any) in which you now live |
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Witnesses are required ONLY if this certificate has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the person completing this certificate must sign below, giving their full addresses.

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| 1. Signature of Witness | 2. Signature of Witness |
| Address <i>(Number and Street, City, State and ZIP Code)</i> | Address <i>(Number and Street, City, State and ZIP Code)</i> |

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 2 minutes to read the instructions, gather the facts, and answer the questions. **SEND 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.** *You may send comments on our time estimate above to: SSA, 1338 Annex Building, Baltimore, MD 21235-0001. Send only comments relating to our time estimate to this address, not the completed form.*