

APPLICATION FOR WIDOW'S OR WIDOWER'S INSURANCE BENEFITS*

(Do not write in this space)

Insert text "For additional information about this application a fact sheet to Form SSA-10 is available at www.socialsecurity.gov."

I apply for all insurance benefits for which I am eligible under Title II (Federal Old-Age, Survivors, and Disability Insurance) and Part A of Title XVIII (Health Insurance for the Aged and Disabled) of the Social Security Act, as presently amended. The information you furnish on this application will ordinarily be sufficient for a determination on the lump-sum death payment.

*This may also be considered an application for survivors benefits under the Railroad Retirement Act and for Veterans Administration payments under title 38 U.S.C., Veterans Benefits, Chapter 13 (which is, as such, an application for other types of death benefits under title 38).

If you were receiving benefits as a wife/husband at the time of your spouse's death, you need complete only the circled items. All other claimants must complete the entire form.

1.	(a) PRINT name of deceased wage earner or self-employed person (<i>herein referred to as the "deceased"</i>) _____	FIRST NAME, MIDDLE INITIAL, LAST NAME
	(b) Check (X) one for the deceased _____	<input type="checkbox"/> Male <input type="checkbox"/> Female
	(c) Enter deceased's Social Security Number _____	_____
2.	(a) PRINT your name _____	FIRST NAME, MIDDLE INITIAL, LAST NAME
	(b) Enter your Social Security Number _____	_____
	(c) Enter your name at birth if different from item 2(a) _____	FIRST NAME, MIDDLE INITIAL, LAST NAME

PART I -- INFORMATION ABOUT THE DECEASED

3.	Enter date of birth of deceased _____	MONTH, DAY, YEAR
4.	(a) Enter date of death _____	MONTH, DAY, YEAR
	(b) Enter place of death _____	CITY AND STATE
5.	Enter name of the State or foreign country where the deceased had a fixed, permanent home at the time of death. _____	
6.	(a) Did the deceased ever file an application for Social Security benefits, a period of disability under Social Security, supplemental security income, or hospital or medical insurance under Medicare? <i>If unknown, check this block</i> <input type="checkbox"/> _____	<input type="checkbox"/> Yes <i>(If "Yes," answer (b) and (c).)</i> <input type="checkbox"/> No <i>(If "No," go on to item 7.)</i>
	(b) Enter name(s) of person(s) on whose Social Security record(s) other application was filed. _____	FIRST NAME, MIDDLE INITIAL, LAST NAME
	(c) Enter Social Security Number(s) of person(s) named in (b). <i>If unknown, check this block</i> <input type="checkbox"/> _____	_____

Answer Item 7 Only if the Deceased Died Prior to Full Retirement Age or Prior to 1 Year Past Full Retirement Age, and Within the Past 4 Months.

7.	(a) Was the deceased unable to work because of illnesses, injuries or conditions at the time of death? _____	<input type="checkbox"/> Yes <i>(If "Yes," answer (b).)</i> <input type="checkbox"/> No <i>(If "No," go on to item 8.)</i>
	(b) Enter the date the deceased became unable to work. _____	MONTH, DAY, YEAR
8.	(a) Was the deceased in the active military or naval service (including Reserve or National Guard <i>active</i> duty or active duty for training) after September 7, 1939 and before 1968? _____	<input type="checkbox"/> Yes <i>(If "Yes," answer (b) and (c).)</i> <input type="checkbox"/> No <i>(If "No," go on to item 9.)</i>
	(b) Enter dates of service. _____	FROM: _____ TO: _____ <i>(Month, year)</i> <i>(Month, year)</i>
	(c) Has anyone (including the deceased) received, or does anyone expect to receive, a benefit from any other Federal agency? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

ANSWER ITEM 9 ONLY IF DEATH OCCURRED WITHIN THE LAST 2 YEARS.

9.	(a) About how much did the deceased earn from employment and self-employment during the year of death? _____	Amount \$
	(b) About how much did the deceased earn the year before death? _____	Amount \$
10	(a) Did the deceased have wages or self-employment income covered under Social Security in all years from 1978 through last year? _____	<input type="checkbox"/> Yes <i>(If "Yes," skip to item 11.)</i> <input type="checkbox"/> No <i>(If "No," answer (b).)</i>
	(b) List the years from 1978 through last year in which the deceased did not have wages or self-employment income covered under Social Security. _____	

11. **CHECK IF APPLICABLE:**
 I am not submitting evidence of the deceased's earnings that are not yet on his/her earnings record. I understand that these earnings will be included automatically within 24 months, and any increase in my benefits will be paid with full retroactivity.

12. Enter below the information requested about each marriage of the deceased, including the marriage to you.

To whom married		When (Month, Day, and Year)	Where (Enter name of City and State)
Last marriage of the deceased	How marriage ended	When (Month, Day, and Year)	Where (Enter name of City and State)
	Marriage performed by: <input type="checkbox"/> Clergyman or public official <input type="checkbox"/> Other (Explain in Remarks)	Spouse's date of birth	If spouse deceased, give date of death
	Spouse's Social Security Number (If none or unknown, so indicate) _____		
	To whom married		When (Month, Day, and Year)
Previous marriage of the deceased (IF NONE, WRITE "NONE.")	How marriage ended	When (Month, Day, and Year)	Where (Enter name of City and State)
	Marriage performed by: <input type="checkbox"/> Clergyman or public official <input type="checkbox"/> Other (Explain in Remarks)	Spouse's date of birth	If spouse deceased, give date of death
	Spouse's Social Security Number (If none or unknown, so indicate) _____		
	To whom married		When (Month, Day, and Year)

← Insert text "INFORAMTION ABOUT THE DECEASED'S MARRIAGE(S)" here

See addendum for replacement text for question #12.

Insert text "as described in 12b" here.

USE "REMARKS" SPACE ON BACK PAGE FOR INFORMATION ABOUT ANY OTHER PREVIOUS MARRIAGE

13. Is there a surviving parent (or parents) who was receiving support from the deceased at the time of death or at the time the deceased became disabled under Social Security Law? _____

Yes No
(If "Yes," enter the name and address in "Remarks.")

PART II -- INFORMATION ABOUT YOURSELF

14. (a) Enter name of State or foreign country where you were born. _____

If you have already presented, or if you are now presenting, a public or religious record of your birth established before you were age 5, go on to item 15.

(b) Was a public record of your birth made before age 5? _____

Yes No Unknown

(c) Was a religious record of your birth made before age 5? _____

Yes No Unknown

Insert text "INFORMATION ABOUT YOUR MARRIAGE(S)"

15.

Enter below information about each of your marriages. Indicate your marriage to the deceased by entering deceased's name (if you are applying for widower's benefits, enter the maiden name of the deceased); it is not necessary to repeat other information about this marriage you have already given in item 12. Enter complete information on all other marriages, whether before or after you married the deceased.

To whom married		When (Month, Day, and Year)	Where (Enter name of City and State)
Your current or last marriage	How marriage ended	When (Month, Day, and Year)	Where (Enter name of City and State)
	Marriage performed by: <input type="checkbox"/> Clergyman or public official <input type="checkbox"/> Other (Explain in Remarks)	Spouse's date of birth	If spouse deceased, give date of death
	Spouse's Social Security Number (If none or unknown, so indicate) _____		
To whom married		When (Month, Day, and Year)	Where (Enter name of City and State)
Your previous marriage (IF NONE WRITE "NONE")	How marriage ended	When (Month, Day, and Year)	Where (Enter name of City and State)
	Marriage performed by: <input type="checkbox"/> Clergyman or public official <input type="checkbox"/> Other (Explain in Remarks)	Spouse's date of birth	If spouse deceased, give date of death
	Spouse's Social Security Number (If none or unknown, so indicate) _____		

See addendum for replacement text for question #15.

insert "on back of page"

insert text "as described in 15c"

USE "REMARKS" SPACE FOR INFORMATION ABOUT ANY OTHER MARRIAGE

IF YOU ARE APPLYING FOR SURVIVING DIVORCED SPOUSE'S BENEFITS, OMIT 16 AND GO ON TO ITEM 17.

16.

(a) Were you and the deceased living together at the same address when the deceased died? _____

Yes (If "Yes," skip to item 17.) No (If "No," answer (b).)

(b) If either you or the deceased were away from home (whether or not temporarily) when the deceased died, give the following:
Who was away? _____ Deceased Surviving spouse

Date last at home: _____ Reason absence began: _____ Reason you were apart at time of death: _____

If separated because of illness, enter nature of illness or disabling condition.

17.

(a) Have you (or has someone on your behalf) ever filed an application for Social Security benefits, a period of disability under Social Security, supplemental security income, or hospital or medical insurance under Medicare? _____

Yes (If "Yes," answer (b) and (c).) No (If "No," go on to item 18.)

(b) Enter name of person on whose Social Security record you filed other application _____

(c) Enter Social Security Number of person named in (b). (if unknown, so indicate) _____

DO NOT ANSWER QUESTION 18 IF YOU ARE FULL RETIREMENT AGE OR OLDER. GO ON TO QUESTION 19.

18.	(a) Are you, or during the past 14 months have you been, unable to work because of illnesses, injuries or conditions? _____	<input type="checkbox"/> Yes <i>(If "Yes," answer (b) .)</i>	<input type="checkbox"/> No <i>(If "No," go on to item 19.)</i>
	(b) Enter the date you became unable to work. _____	(Month, day, year)	
19.	Were you in the active military or naval service (including Reserve or National Guard <i>active</i> duty or active duty for training) after September 7, 1939 and before 1968? _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
20.	Did you or the deceased work in the railroad industry for 5 years or more? _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
21.	(a) Did you or the deceased have Social Security credits (for example, based on work or residence) under another country's Social Security System? _____	<input type="checkbox"/> Yes <i>(If "Yes," answer (b).)</i>	<input type="checkbox"/> No <i>(If "No," go on to item 22.)</i>
	(b) If "Yes," list the country(ies). _____		
22.	(a) Have you qualified for, or do you expect to qualify for, a pension or annuity (or a lump sum in place of a pension or annuity) based on your own employment and earnings for the Federal Government of the United States, or one of its States or local subdivisions? <i>(Social Security benefits are not government pensions.)</i> _____	<input type="checkbox"/> Yes <i>(If "Yes," check which of the items in item (b) applies to you.)</i>	<input type="checkbox"/> No <i>(If "No," go on to item 23.)</i>
	(b) <input type="checkbox"/> I receive a government pension or annuity. <input type="checkbox"/> I received a lump sum in place of a government pension or annuity. <input type="checkbox"/> I applied for and am awaiting a decision on my pension or lump sum.	<input type="checkbox"/> I have not applied for but I expect to begin receiving my pension or annuity: _____ (Month, year) <i>(If the date is not known, enter "Unknown".)</i>	

See addendum (New Language)
MEDICARE INFORMATION

MEDICARE INFORMATION

If this claim is approved and you are still entitled to benefits at age 65, you will automatically receive Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance) coverage at age 65. If you are not eligible for automatic enrollment in Medicare Part B, this application may be used for voluntary enrollment.

COMPLETE ITEM 23 ONLY IF YOU ARE WITHIN 3 MONTHS OF AGE 65 OR OLDER

In most cases, Medicare does not pay for health care you get while traveling outside the United States. Your local Social Security Office will be glad to explain more about Medicare.

Enrollment in Medicare Part B (Medical Insurance): Medicare Part B helps cover doctor's services and outpatient care. It also covers some other services that Medicare Part A doesn't cover. Once you are enrolled in Medicare Part B, you will have to pay a monthly premium. The date your Medicare Part B begins and the amount of the premium you must pay depends on the month you filed this application with the Social Security Administration. Your premiums will be deducted from any monthly Social Security, Railroad Retirement, or Office of Personnel Management benefit check you receive. If you do not receive such benefits, you will be notified how to pay your premiums. You will get advance notice if there is any change in your premium amount.

If you do not enroll in Medicare Part B now, you can enroll later only during a specified enrollment period. If you enroll later, your coverage may be delayed and you may have to pay a higher premium.

23.	Do you want to enroll in the Medicare Part B (Medical Insurance)? _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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ANSWER ITEM 24 ONLY IF THE DECEASED DIED BEFORE THIS YEAR.

24.	(a) How much were your total earnings last year? _____ →	\$				
	(b) Place an "X" in each block for each month of last year in which you <u>did not earn</u> more than *\$ _____ in wages, and <u>did not perform</u> substantial services in self-employment. These months are exempt months. If no months were exempt months, place an "X" in "NONE." If all months were exempt months, place an "X" in "ALL." *Enter the appropriate monthly limit after reading the instructions, " <u>How Your Earnings Affect Your Benefits.</u> "		NONE		ALL	
		Jan.	Feb.	Mar.	Apr.	
		May	Jun.	Jul.	Aug.	
		Sept.	Oct.	Nov.	Dec.	

ANSWER ITEM 26 ONLY IF YOU ARE NOW IN THE LAST 4 MONTHS OF YOUR TAXABLE YEAR (SEPT., OCT., NOV., AND DEC., IF YOUR TAXABLE YEAR IS A CALENDAR YEAR).

26.	(a) How much do you expect to earn next year? _____ →	\$				
	(b) Place an "X" in each block for each month of next year in which you <u>do not expect to earn</u> more than *\$ _____ in wages, and <u>do not expect to perform</u> substantial services in self-employment. These months will be exempt months. If no months are expected to be exempt months, place an "X" in "NONE." If all months are expected to be exempt months, place an "X" in "ALL." *Enter the appropriate monthly limit after reading the instructions, " <u>How Your Earnings Affect Your Benefits.</u> "		NONE		ALL	
		Jan.	Feb.	Mar.	Apr.	
		May	Jun.	Jul.	Aug.	
		Sept.	Oct.	Nov.	Dec.	

27. If you use a fiscal year, that is, a taxable year that does not end December 31 (with income tax return due April 15), enter here the month your fiscal year ends. _____ → Month

IF YOU ARE FULL RETIREMENT AGE OR OLDER, GO ON TO PAGE 6. OTHERWISE, PLEASE READ CAREFULLY THE INFORMATION ON PAGE 8 AND ANSWER ONE OF THE FOLLOWING ITEMS.

28. (a) I want benefits beginning with the earliest possible month ~~that will be the most advantageous.~~ _____ →

delete text

(b) I am full retirement age (or will be within 4 months) and I want benefits beginning with the earliest possible month ~~that will be the most advantageous,~~ providing that there is no permanent reduction in my ongoing monthly benefits. _____ →

(c) I want benefits beginning with _____. I understand that either a higher initial payment or a higher continuing monthly benefit amount may be possible, but I choose not to take it. _____ →

ANSWER QUESTION 29 ONLY IF YOU ARE NOW AT LEAST AGE 61 YEARS, 8 MONTHS.

29. Do you wish this application to be considered an application for retirement benefits on your own earnings record? _____ → Yes No

Remove questions
#30 and #31.

30.	Do you have any unsatisfied felony warrants for your arrest? _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
31.	Do you have any unsatisfied Federal or State warrants for your arrest for violating the conditions of your probation or parole? _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No

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

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. I understand that anyone who knowingly gives a false or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime and may be sent to prison, or may face other penalties, or both.

SIGNATURE OF APPLICANT	Date (<i>Month, day, year</i>)
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Signature (<i>First name, middle initial, last name</i>) (Write in ink)	Telephone number(s) at which you may be contacted during the day _____ AREA CODE _____
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**SIGN
HERE** 

FOR OFFICIAL USE ONLY	Direct Deposit Payment Address (<i>Financial Institution</i>)			<input type="checkbox"/> No Account <input type="checkbox"/> Direct Deposit Refused
	Routing Transit Number	C/S	Depositor Account Number	

Applicant's Mailing Address (*Number and street, Apt. No., P.O. Box, or Rural Route*) (Enter Residence Address in "Remarks," if different.)

City and State	ZIP Code	Country (<i>if any</i>) in which you now live
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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. Also, print the applicant's name in the Signature block.

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>)

RECEIPT FOR YOUR CLAIM FOR SOCIAL SECURITY WIDOW'S OR WIDOWER'S INSURANCE BENEFITS

TELEPHONE NUMBER(S) TO CALL IF YOU HAVE A QUESTION OR SOMETHING TO REPORT	BEFORE YOU RECEIVE A NOTICE OF AWARD	SSA OFFICE	DATE CLAIM RECEIVED
	AFTER YOU RECEIVE A NOTICE OF AWARD		

Your application for Social Security benefits has been received and will be processed as quickly as possible.

You should hear from us within _____ days after you have given us all the information we requested. Some claims may take longer if additional information is needed.

In the meantime, if you change your address, or if there is some other change that may affect your claim, you--or someone for you--should report the change. The changes to be reported are listed on page 8. Always give us your claim number when writing or telephoning about your claim.

If you have any questions about your claim, we will be glad to help you.

CLAIMANT	DECEASED'S SURNAME IF DIFFERENT FROM CLAIMANT'S	SOCIAL SECURITY CLAIM NUMBER
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Collection and Use of Information From Your Application - Privacy Act Notice/Paperwork Act Notice

The Social Security Administration is authorized to collect the information on this form under sections 202, 205, and 223 of the Social Security Act. The information you provide will be used by the Social Security Administration to determine if you or a dependent is eligible to insurance coverage and/or monthly benefits. You do not have to give us the requested information. However, if you do not provide the information, we will be unable to make an accurate and timely decision concerning your entitlement or a dependent's entitlement to benefit payments.

The information you provide may be disclosed to another Federal, State or local government agency for determining eligibility for a government benefit or program, to a Congressional office requesting information on your behalf, to an independent party for performance of research and statistical activities, or to the Department of Justice for use in representing the Federal government.

We may also use this information 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.

Explanations about these and other reasons why information you provide may be used or given out are available in Social Security offices. If you want to learn more about this, contact any Social Security office.

**See revised
Privacy Act and
Paperwork
Reduction Act
Statements below.**

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 15 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. 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.**

CHANGES TO BE REPORTED AND HOW TO REPORT

FAILURE TO REPORT MAY RESULT IN OVERPAYMENTS THAT MUST BE REPAYED, AND IN POSSIBLE MONETARY PENALTIES

- ▶ You change your mailing address for checks or residence. *(To avoid delay in receipt of checks you should ALSO file a regular change of address notice with your post office.)*
 - ▶ Your citizenship or immigration status changes.
 - ▶ You go outside the U.S.A. for 30 consecutive days or longer.
 - ▶ Any beneficiary dies or becomes unable to handle benefits.
 - ▶ Work Changes -- On your application you told us you expect total earnings for _____ to be \$ _____ .
- ▶ You have an unsatisfied warrant for your arrest for a crime or attempted crime that is a felony (or, in jurisdictions that do not define crimes as felonies, a crime that is punishable by death or imprisonment for a term exceeding 1 year.)
 - ▶ You have an unsatisfied warrant for a violation of probation or parole under Federal or State law.

Disability Applicants

1. You return to work (as an employee or self-employed) regardless of amount of earnings.
2. Your condition improves.

HOW TO REPORT

Insert heading Work and Earnings

You can make your reports by telephone, mail, or in person, whichever you prefer.

If you are awarded benefits, and one or more of the above change(s) occur, you should report by:

- ▶ Calling us TOLL FREE at 1-800-772-1213;
- ▶ If you are deaf or hearing impaired, calling us TOLL FREE at TTY 1-800-325-0778; or
- ▶ Calling, visiting or writing your local Social Security office shown on your claim receipt.

For general information about Social Security, visit our web site at www.socialsecurity.gov.

For those under full retirement age, the law requires that a report of earnings be filed with SSA within 3 months and 15 days after the end of any taxable year in which you earn more than the annual exempt amount. You may contact SSA to file a report. Otherwise, SSA will use the earnings reported by your employer(s) and your self-employment tax return (if applicable) as the report of earnings required by law and adjust benefits under the earnings test. It is your responsibility to ensure that the information you give concerning your earnings is correct. You must furnish additional information as needed when your benefit adjustment is not correct based on the earnings on your record.

Move this text under heading "Work and Earnings" (above).

You (are) (are not) earning wages of more than \$ _____ a month.

You (are) (are not) self-employed rendering substantial services in your trade or business.

(Report AT ONCE if this work pattern changes.)

- ▶ Change of Marital Status - Marriage, divorce, annulment of marriage. You must report marriage even if you believe that an exception applies.
- ▶ You are confined to jail, prison, penal institution or correctional facility for conviction of a crime or you are confined to a public institution by court order in connection with a crime.
- ▶ Custody Change - Report if a person for whom you are filing, or who is in your care dies, leaves your care or custody, or changes address.
- ▶ You begin to receive a government pension or annuity (from the Federal government or any State or any political subdivision thereof) or your pension or annuity amount changes.

insert text "at the phone number and address"

FIGURING YOUR ANNUAL EARNINGS

To figure your total yearly earnings, count all gross wages (before deductions) and net earnings from self-employment which you earn during the entire year. This includes earnings both before and after retirement, and applies to all earned income whether or not covered by Social Security.

In figuring your total yearly earnings, however, DO NOT COUNT ANY AMOUNTS EARNED BEGINNING WITH THE MONTH YOU ATTAIN FULL RETIREMENT AGE. Count only amounts earned before the month you attain full retirement age.

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY BEFORE ANSWERING QUESTION 28.

Benefits may be payable for some months prior to the month in which you file this claim (but not for any month before you reach age 60 (unless you are disabled)) if:

- ▶ YOU WILL EARN OVER THE EXEMPT AMOUNT THIS YEAR.

(For the appropriate exempt amount, see "How Your Earnings Affect Your Benefits.")

If your first month of entitlement is prior to full retirement age, your benefit rate will be reduced. However, if you do not actually receive your full benefit amount for one or more months before full retirement age because benefits are withheld due to your earnings, your benefit will be increased at full retirement age to give credit for this withholding. Thus, your benefit amount at full retirement age will be reduced only if you receive one or more full benefit payments prior to the month you attain full retirement age.

SS-10-BK, Application for Widow's or Widower's Insurance Benefits

PRIVACY ACT NOTICE

Collection and Use of Personal Information

Sections 202, 205 and 223 of the Social Security Act, as amended, authorize us to collect the information requested on this form. The information you provide will be used to make a decision on this claim. Your response is voluntary. However, failure to provide the requested information may prevent an accurate and timely decision on any claim filed, or could result in the loss of benefits.

We rarely use the information provided on this form for any purpose other than for determining entitlement to Social Security benefits. However, in accordance with 5 U.S.C. § 552a(b) of the Privacy Act, we may disclose the information provided on this form in accordance with approved routine uses which include, but are not limited to, the following:

1. To enable an agency or third party to assist Social Security in establishing rights to Social Security benefits and/or coverage;
2. To make determinations for eligibility in similar health and income maintenance programs at the Federal, State and local level;
3. To comply with Federal laws requiring the disclosure of the information from our records; and
4. To facilitate statistical research, audit or investigative activities necessary to assure the integrity of SSA programs.

We may also use the information you provide when we match records by computer. Computer matching programs compare our records with those of 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.

A complete list of routine uses for this information is contained in our System of Records Notice 60-0089 (Claims Folders Systems). Additional information regarding this form and other systems of records notices and Social Security programs are available from our Internet website at www.socialsecurity.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 15 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED REPORT TO YOUR LOCAL SOCIAL SECURITY OFFICE, THE NEAREST U.S EMBASSY OR CONSULATE OFFICE.** You can find your local Social Security office through SSA's website at www.socialsecurity.gov. Offices are also listed under U.S. Government agencies in your telephone directory or you may call 1-800-772-1213 (TTY 1-800-325-0778) for the address. *You may send comments on our time estimate above to: SSA, 6401 Security Boulevard, Baltimore, MD 21235-6401. Send only comments relating to our time estimate to this address, not the completed report.*

REPORTING RESPONSIBILITIES FOR WIDOW'S OR WIDOWER'S INSURANCE BENEFITS 0004

List will be bullets

CHANGES TO BE REPORTED AND HOW TO REPORT
TO REPORT MAY RESULT IN OVERPAYMENTS THAT MUST BE
REPAID, AND IN POSSIBLE MONETARY PENALTIES

You change your mailing address for checks or residence. *(To avoid delay in receipt of checks you should ALSO file a regular change of address notice with your post office.)*

You begin to receive a government pension or annuity (from the Federal government or any State or any political subdivision thereof) or your pension or annuity amount changes.

>Your citizenship or immigration status changes.

You have an unsatisfied warrant for your arrest for a crime or attempted crime that is a felony (or, in jurisdictions that do not define crimes as felonies, a crime that is punishable by death or imprisonment for a term exceeding 1 year.)

> You go outside the U.S.A. for 30 consecutive days or longer.

You have an unsatisfied warrant for a violation of probation or parole under Federal or State law.

>Any beneficiary dies or becomes unable to handle benefits.

> Work Changes - On your application you told us you expect total earnings for _____ to be \$ _____ .

Insert heading Work and Earnings

HOW TO REPORT

You (are) (are not) earning wages of more than \$ _____ a month.

You can make your reports by telephone, mail, or in person, whichever you prefer.

You (are) (are not) self-employed rendering substantial services in your trade or business.

If you are awarded benefits, and one or more of the above change(s) occur, you should report by:

- > Calling us TOLL FREE at 1-800-772-1213;
- + If you are deaf or hearing impaired, calling us TOLL FREE at TTY 1-800-325-0778; or ». Calling, visiting or writing your local Social Security office shown on your claim receipt.

(Report AT ONCE if this work pattern changes)

For general information about Social Security, visit our web site at www.socialsecurity.gov.

>Change of Marital Status - Marriage, divorce, annulment of marriage. You must report marriage even if you believe that an exception applies.

For those under full retirement age, the law requires that a report of earnings be filed with SSA within 3 months and 15 days after the end of any taxable year in which you earn more than the annual exempt amount. You may contact SSA to file a report. Otherwise, SSA will use the earnings reported by your employer(s) and your self-employment tax return (if applicable) as the report of earnings required by law and adjust benefits under the earnings test. It is your responsibility to ensure that the information you give concerning your earnings is correct. You must furnish additional information as needed when your benefit adjustment is not correct based on the earnings on your record.

>Custody Change or Disability Improves - Report if a person for whom you're filing, or who is in your care dies, leaves your care or custody, changes address, or, if disabled, the condition improves.

(Move highlighted paragraph to over the caption that reads "How to report")

>You are confined to jail, prison, penal institution or correctional facility for conviction of a crime or you are confined to a public institution by court order in connection with a crime.

insert text "at the phone number and address"

NOTICE ABOUT DOCUMENTS

We recommend that you keep all documents you submitted to us.

We are returning the documents you submitted with this claim.

Collection and Use of Information From Your Application
Privacy Act Notice/~~Paperwork Act Notice~~

~~The Social Security Administration is authorized to collect the information on this form under sections 202, 205, and 223 of the Social Security Act. The information you provide will be used by the Social Security Administration to determine if you or a dependent is eligible to insurance coverage and/or monthly benefits. You do not have to give us the requested information. However, if you do not provide the information, we will be unable to make an accurate and timely decision concerning your entitlement or a dependent's entitlement to benefit payments.~~

~~The information you provide may be disclosed to another Federal, State or local government agency for determining eligibility for a government benefit or program, to a Congressional office requesting information on your behalf, to an independent party for performance of research and statistical activities, or to the Department of Justice for use in representing the Federal government.~~

~~We may also use this information 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.~~

~~Explanations about these and other reasons why information you provide may be used or given out are available in Social Security offices. If you want to learn more about this, contact any Social Security office.~~

See revised Privacy Act and Paperwork
Reduction Act statements below.

~~**Paperwork Reduction Act Notice** - 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 15 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.**~~

SS-10-BK, Application for Widow's or Widower's Insurance Benefits

PRIVACY ACT NOTICE

Collection and Use of Personal Information

Sections 202, 205 and 223 of the Social Security Act, as amended, authorize us to collect the information requested on this form. The information you provide will be used to make a decision on this claim. Your response is voluntary. However, failure to provide the requested information may prevent an accurate and timely decision on any claim filed, or could result in the loss of benefits.

We rarely use the information provided on this form for any purpose other than for determining entitlement to Social Security benefits. However, in accordance with 5 U.S.C. § 552a(b) of the Privacy Act, we may disclose the information provided on this form in accordance with approved routine uses which include, but are not limited to, the following:

1. To enable an agency or third party to assist Social Security in establishing rights to Social Security benefits and/or coverage;
2. To make determinations for eligibility in similar health and income maintenance programs at the Federal, State and local level;
3. To comply with Federal laws requiring the disclosure of the information from our records; and
4. To facilitate statistical research, audit or investigative activities necessary to assure the integrity of SSA programs.

We may also use the information you provide when we match records by computer. Computer matching programs compare our records with those of 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.

A complete list of routine uses for this information is contained in our System of Records Notice 60-0089 (Claims Folders Systems). Additional information regarding this form and other systems of records notices and Social Security programs are available from our Internet website at www.socialsecurity.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 15 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED REPORT TO YOUR LOCAL SOCIAL SECURITY OFFICE, THE NEAREST U.S EMBASSY OR CONSULATE OFFICE.** You can find your local Social Security office through SSA's website at www.socialsecurity.gov. Offices are also listed under U.S. Government agencies in your telephone directory or you may call 1-800-772-1213 (TTY 1-800-325-0778) for the address. *You may send comments on our time estimate above to: SSA, 6401 Security Boulevard, Baltimore, MD 21235-6401. Send only comments relating to our time estimate to this address, not the completed report.*