

APPLICATION FOR RETIREMENT INSURANCE BENEFITS

(Do not write in this space)

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.

Supplement. If you have already completed an application entitled "APPLICATION FOR WIFE'S OR HUSBAND'S INSURANCE BENEFITS", you need complete only the circled items. All other claimants must complete the entire form.

1. (a) PRINT your name FIRST NAME, MIDDLE INITIAL, LAST NAME
(b) Check (X) whether you are Male Female
2. Enter your Social Security number
3. If this claim is awarded, do you want a password to use SSA's Internet/phone service? Yes No

Answer question 4 if English is not your language preference. Otherwise, go to item 5.

4. Enter the language you prefer to: Speak Write
5. (a) Enter your date of birth Month, Day, Year
(b) Enter name of State or foreign country where you were born.
(c) Was a public record of your birth made before you were age 5? Yes No Unknown
(d) Was a religious record of your birth made before you were age 5? Yes No Unknown
6. (a) Are you a U.S. citizen? Yes No (Go to item 8.) (Go to item (b).)
(b) Are you an alien lawfully present in U.S.? Yes No
7. Enter your full name at birth if different from item 1(a) FIRST NAME, MIDDLE INITIAL, LAST NAME
8. (a) Have you used any other name(s)? Yes No (Go to item (b).) (Go to item 9.)
(b) Other names(s) used.
9. (a) Have you used any other Social Security number(s)? Yes No (Go to item (b)) (Go to item 10.)
(b) Enter Social Security number(s) used.

Do not answer question 10 if you are one year past full retirement age or older; go to question 11.

10.	(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	<input type="checkbox"/> No	
	(b) If "Yes", enter the date you became unable to work. _____ →	MONTH, DAY, YEAR		
11.	(a) Have you (or has someone on your behalf) ever filed an application for Social Security, Supplemental Security Income, or hospital or medical insurance under Medicare? _____ →	<input type="checkbox"/> Yes <i>(If "Yes," answer (b) and (c).)</i>	<input type="checkbox"/> No <i>(If "No," go to item 12.)</i>	<input type="checkbox"/> Unknown <i>(If "Unknown," go to item 12.)</i>
	(b) Enter name of person(s) on whose Social Security record you filed other application. _____ →	FIRST NAME, MIDDLE INITIAL, LAST NAME		
	(c) Enter Social Security number(s) of person named in (b). (If unknown, so indicate.) _____ →	- -		

If you are now AGE 62 or older, or you will be AGE 62 in this month or one of the next 4 months, answer question 12. Otherwise, go to question 13.

(12)	(a) Were you in the active military or naval service (including Reserve or National Guard active 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 to item 13.)</i>
	(b) Enter date(s) of service _____ →	From: Month, Year	To: Month, Year
	(c) Have you <u>ever</u> been (or will you be) eligible for monthly benefits from a military or civilian Federal agency? (including Veterans Administration benefits <u>only</u> if you waived Military retirement pay) _____ →	<input type="checkbox"/> Yes	<input type="checkbox"/> No
13.	Did you or your spouse (or prior spouse) work in the railroad industry for 5 years or more? _____ →	<input type="checkbox"/> Yes	<input type="checkbox"/> No
14.	(a) Do you (or your spouse) 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) and (c).)</i>	<input type="checkbox"/> No <i>(If "No," go to item 15.)</i>
	(b) List the country(ies): _____ →		
	(c) Are you (or your spouse) filing for foreign Social Security benefits? _____ →	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Answer question 15 only if you were born January 2, 1924, or later. Otherwise go on to question 16.

(15)	(a) Are you entitled to, or do you expect to be entitled to, a pension or annuity based on your work after 1956 not covered by Social Security? _____ →	<input type="checkbox"/> Yes <i>(If "Yes," answer (b) and (c).)</i>	<input type="checkbox"/> No <i>(If "No," go on to item 16.)</i>
	(b) <input type="checkbox"/> I became entitled, or expect to become entitled, beginning _____ →	MONTH	YEAR
	(c) <input type="checkbox"/> I became eligible, or expect to become eligible, beginning _____ →	MONTH	YEAR

16. Have you been married? _____ →	<input type="checkbox"/> Yes <i>(If "Yes," answer item 17.)</i>	<input type="checkbox"/> No <i>(If "No," go to item 18.)</i>
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17. (a) Give the following information about your current marriage. If not currently married, show your last marriage here:

To whom married	When (Month, day, year)	Where (Name of City and State)	
Current or last marriage	How marriage ended (If still in effect, write "Not Ended.")	When (Month, day, year)	
	Marriage performed by: <input type="checkbox"/> Clergyman or public official <input type="checkbox"/> Other (Explain in Remarks)	Spouse's date of birth (or age)	If spouse deceased, give date of death
	Spouse's Social Security Number (If none or unknown, so indicate)		

(b) Give the following information about each of your previous marriages. (IF NONE, WRITE "NONE")

To whom married	When (Month, day, year)	Where (Name of City and State)	
Your previous marriage (Use a separate statement for information about any other marriages.)	How marriage ended	When (Month, day, year)	
	Marriage performed by: <input type="checkbox"/> Clergyman or public official <input type="checkbox"/> Other (Explain in Remarks)	Spouse's date of birth (or age)	If spouse deceased, give date of death
	Spouse's Social Security Number (If none or unknown, so indicate)		

18. List below FULL NAME OF ALL your children (including natural children, adopted children, and stepchildren) or dependent grandchildren (including stepgrandchildren) who are now or were in the past 6 months UNMARRIED and:

- UNDER AGE 18 ▪ AGE 18 TO 19 AND ATTENDING SECONDARY SCHOOL
- DISABLED OR HANDICAPPED (age 18 or over and disability began before age 22)

Also list any student who is between the ages of 18 to 23 if such student was both: 1. Previously entitled to Social Security benefits on any Social Security record for August 1981; and 2. In full-time attendance at a post-secondary school prior to May 1982.

(IF THERE ARE NO SUCH CHILDREN. WRITE "NONE" BELOW AND GO ON TO ITEM 19.)

19.	(a) Did you have wages or self-employment income covered under Social Security in all years from 1978 through last year?	<input type="checkbox"/> Yes (If "Yes," go to item 20.)	<input type="checkbox"/> No (If "No," answer item (b).)
	(b) List the years from 1978 through last year in which you did not have wages or self-employment income covered under Social Security.		

20.	(a) Enter below the names and addresses of all the persons, companies, or government agencies for whom you have worked this year, last year, and the year before last. IF NONE, WRITE "NONE" BELOW AND GO ON TO ITEM 21.			
	NAME AND ADDRESS OF EMPLOYER (If you had more than one employer, please list them in order beginning with your last (most recent) employer.)	Work Began		Work Ended (If still working, show "Not Ended")
		Month	Year	Month

(If you need more space, use "Remarks".)

(b) Are you an officer of a corporation, or are you related to an officer of a corporation? _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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21. May we ask your employers for wage information needed to process your claim? _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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22. THIS ITEM MUST BE COMPLETED, EVEN IF YOU ARE AN EMPLOYEE. (a) Were you self-employed this year and/or last year? _____	<input type="checkbox"/> Yes (If "Yes," answer (b).)	<input type="checkbox"/> No (If "No," go to item 23.)
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(b) Check the year or years in which you were self-employed	In what kind of trade or business were you self-employed? (For example, storekeeper, farmer, physician)	Were your net earnings from your trade or business \$400 or more? (Check "Yes" or "No")
<input type="checkbox"/> This year		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Last year		<input type="checkbox"/> Yes <input type="checkbox"/> No

23. (a) How much were your total earnings last year? _____ Amount \$ _____
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(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.

24. (a) How much do you expect your total earnings to be this year? _____ Amount \$ _____

(b) Place an "X" in each block for EACH MONTH of this year in which you <u>did not or will not earn</u> more than *\$_____ in wages, and <u>did not or will not perform</u> substantial services in self-employment. These months are exempt months. If no months are or will be exempt months, place an "X" in "NONE". If all months are or will 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.

Answer this item 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).

25. (a) How much do you expect to earn next year? _____ Amount \$ _____

(b) Place an "X" in each block for EACH MONTH of next year in which you do not expect to earn more than *\$_____ in wages, and do not expect to perform 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".

NONE		ALL	
Jan.	Feb.	Mar.	Apr.
May	Jun.	Jul.	Aug.
Sept.	Oct.	Nov.	Dec.

*Enter the appropriate monthly limit after reading the instructions, "How Your Earnings Affect Your Benefits".

26. 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) _____

DO NOT ANSWER ITEM 27 IF YOU ARE FULL RETIREMENT AGE AND 6 MONTHS OR OLDER; GO TO ITEM 28.

PLEASE READ CAREFULLY THE INFORMATION ON THE BOTTOM OF PAGE 8 AND ANSWER ONE OF THE FOLLOWING ITEMS:

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

(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 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. _____

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 28 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.

28. Do you want to enroll in Medicare Part B (Medical insurance)? _____ Yes No

29. If you are within 2 months of age 65 or older, blind or disabled, do you want to file for Supplemental Security Income? _____ Yes No

30. Do you have any unsatisfied felony warrants for your arrest? _____ Yes No

31. Do you have any unsatisfied Federal or State warrants for your arrest for violating the conditions of your probation or parole? _____ Yes No

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

Multiple horizontal lines for writing remarks.

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 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 face other penalties, or both.

SIGNATURE OF APPLICANT	Date (Month, day, year)
SIGNATURE (First Name, Middle Initial, Last Name) (Write in ink.)	Telephone number(s) at which you may be contacted during the day

SIGN HERE 

FOR OFFICIAL USE ONLY	Direct Deposit Payment Address (Financial Institution)			<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	County (if any) 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 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 (Number and Street, City, State and ZIP Code)	Address (Number and Street, City, State and ZIP Code)

RECEIPT FOR YOUR CLAIM FOR SOCIAL SECURITY RETIREMENT 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	SOCIAL SECURITY CLAIM NUMBER

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

The Social Security Administration is authorized to collect the information requested 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.

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 10.5 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 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.*)
- ▶ 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 $\frac{\text{Year}}{\text{Year}}$ to be \$ _____.
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)
- ▶ 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.
- ▶ 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.
- ▶ You become entitled to a pension or annuity based on your employment after 1956 not covered by Social Security, or if such pension or annuity stops.
- ▶ Your stepchild is entitled to benefits on your record and you and the stepchild's parent divorce. Stepchild benefits are not payable beginning with the month after the month the divorce becomes final.
- ▶ 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.
- ▶ Change of Marital Status - Marriage, divorce, annulment of marriage.

HOW TO REPORT

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 at the phone number and address 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, to 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.

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY BEFORE YOU ANSWER QUESTION 27.

If you are under full retirement age, retirement benefits cannot be payable to you for any month before the month in which you file your claim.

If you are over full retirement age, retirement benefits may be payable to you for some months before the month in which you file this claim (but not before the month you attain full retirement age).

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.