APPLICATION FOR MOTHER'S OR FATHER'S 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.

The information you furnish on this application will ordinarily be sufficient for a determination on the lump-sum death payment. For additional information about this application a fact sheet to Form SSA-5 is available at www.socialsecurity.gov.

***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).**

1.	(a) PRINT name of deceased wage earner or self-employed person *(herein referred to as the "deceased").* →	FIRST NAME, MIDDLE INITIAL, LAST NAME	
	(b) Check (X) one for the deceased. →	☐ Male	☐ 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. →	__ __ __ / __ __ /__ __ __ __	
3.	Enter your name at birth if different from item 2. →		
4.	(a) Enter your date of birth. →	MONTH, DAY, YEAR	
	(b) Enter name of State or foreign country where you were born. →		

Please read carefully before answering item 5

You may receive a mother's or a father's benefit for any month in which you have in your care the deceased's child or dependent grandchild who is entitled to a child's benefit if the child is:

- under age 16,
- or disabled or handicapped (age 16 or over and disability began before age 22).

If you are filing as a surviving divorced mother or father, such child must be your son, daughter, or legally adopted child who is entitled to child's benefits on the deceased's earnings record.
Mother's or father's benefits are not payable if the only child in your care is a child age 16 or over who is not disabled.

5. Has an unmarried child or dependent grandchild of the deceased, who is under age 16 or disabled, lived with you any time from the month of death through the present month? (This includes adopted child, stepchild, and stepgrandchild.)

(If "Yes," enter the information requested below.) → ☐ Yes ☐ No

Name of child	Months child lived with you *(If all, write "All")*

6.	(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 7.)*
	(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.)* →	__ __ __ /__ __ /__ __ __ __	

7.	(a) Are you, or during the past 14 months have you been, unable to work because of illnesses, injuries or conditions? →	☐ Yes ☐ No *(If "Yes," answer (b).)* *(If "No," go on to item 8.)*
	(b) Enter the date you became unable to work. →	Month, Day, Year
8.	Did you work in the railroad industry for 5 years or more? →	☐ Yes ☐ No
9.	(a) Do you have Social Security credits (for example, based on work or residence) under another country's Social Security system? →	☐ Yes ☐ No *(If "Yes," answer (b).)* *(If "No," go on to item 10.)*
	(b) If "Yes," list the country(ies). →	
10.	Is there a surviving parent (or parents) of the deceased who was receiving support from the deceased at the time of death or at the time the deceased become disabled? →	☐ Yes ☐ No *(If "Yes," enter the name and address of the parent(s) in "Remarks".)*

11. INFORMATION ON YOUR MARRIAGE(S)

(a) Enter information about your marriage to the deceased.

Spouse's Name (including maiden name)	When *(Month, day, year)*	Where *(Name of City and State)*
How marriage ended	When *(Month, day, year)*	Where *(Name of City and State)*
Marriage performed by: ☐ **Clergyman or public official** ☐ **Other (Explain in "Remarks")**	Spouse's date of birth (or age)	Date of death

(b)If you remarried **after** the marriage shown in 11. (a), enter information about the last marriage. **(If none, write "NONE").**

Spouse's Name (including maiden name)	When *(Month, day, year)*	Where *(Name of City and State)*
How marriage ended	When *(Month, day, year)*	Where *(Name of City and State)*
Marriage performed by: ☐ **Clergyman or public official** ☐ **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) __ __ __ /__ __ /__ __ __ __

(c) If you had other marriages, and the marriage lasted at least 10 years or ended due to death of the spouse (whether before or after you married the deceased), enter the information below. If you divorced then remarried the same individual within the year immediately following the year of the divorce, and the combined period of marriage totaled 10 years or more, include the marriage. **(If none, write "NONE").**

Spouse's Name (including maiden name)	When *(Month, day, year)*	Where *(Name of City and State)*
How marriage ended	When *(Month, day, year)*	Where *(Name of City and State)*
Marriage performed by: ☐ **Clergyman or public official** ☐ **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)* __ __ __ /__ __ /__ __ __ __

(Use "Remarks" space on next page for continuation)

12. INFORMATION ABOUT THE DECEASED'S MARRIAGE(S)

Answer this item ONLY if the deceased had other marriages.

(a) If the deceased married **after** his or her marriage to you, enter the information on the last marriage. **(If none, write "NONE").**

Spouse's Name (including maiden name)	When *(Month, day, year)*	Where *(Name of City and State)*
How marriage ended	When *(Month, day, year)*	Where *(Name of City and State)*
Marriage performed by: ☐ **Clergyman or public official** ☐ **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)* __ __ __ /__ __ /__ __ __ __

12.

(b) Enter information about any other marriage the deceased may have had that lasted at least 10 years (see item 11. (c) for counting consecutive multiple marriages to the same individual) or ended due to death of the spouse (whether before or after you married the deceased). Do not include the marriage to you. **(If none, write "NONE").** _____

Spouse's Name (including maiden name)	When *(Month, day, year)*	Where *(Name of City and State)*
How marriage ended	When *(Month, day, year)*	Where *(Name of City and State)*
Marriage performed by: ☐ **Clergyman or public official** ☐ **Other (Explain in "Remarks")**	Spouse's date of birth (or age)	Date of death
Spouse's Social Security Number *(If "None" or "Unknown," so indicate)*		__ __ __ / __ __ / __ __ __ __

(Use "Remarks" space below for marriage continuation. Enter complete information.)

If you are applying for surviving divorced spouse's benefits, omit 13 and go on to item 14.

13. (a) Were you and the deceased living together at the same address when the deceased died? ☐ Yes *(If "Yes," go on to item 14.)* ☐ 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?	☐ You ☐ deceased
Reason absence began	
Date last at home	
Reason you were apart at time of death	
If separated because of illness, enter nature of illness or disabling condition	

Answer item 14 ONLY if the deceased died before this year.

14. (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 did not earn more than *$_____ in wages, and did not perform 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, "How Your Earnings Affect Your Benefits".

NONE		ALL
JAN	FEB	MAR
APR	MAY	JUN
JUL	AUG	SEPT
OCT	NOV	DEC

15. (a) How much do you expect your total earnings to be this year? $

(b) Place an "X" in each block for EACH MONTH of this year in which you did not or will not earn more than *$ _____ in wages, and did not or will not perform 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, "How Your Earnings Affect Your Benefits".

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).

16. (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 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".

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

NONE		ALL
JAN	FEB	MAR
APR	MAY	JUN
JUL	AUG	SEPT
OCT	NOV	DEC

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

17.	(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? *(Social Security benefits are not government pensions).* →	☐ Yes ☐ No *(If "Yes," check the box in item (b) that applies.)* *(If "No," go on, to item 18.)*
	(b) ☐ I receive a government pension or annuity. ☐ I received a lump sum in place of a government pension or annuity. ☐ I applied for and am awaiting a decision on my pension or lump sum.	☐ I have not applied for but I expect to begin receiving my pension or annuity: *(If the date is not known, enter "Unknown.")* Month / Year

18. 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.

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 *(Month, day, year)*
Signature *(First Name, Middle Initial, Last Name) (Write in ink)* **SIGN HERE** ▶	Telephone number(s) at which you may be contacted during the day (AREA CODE)

FOR OFFICIAL USE ONLY

Direct Deposit Payment Address *(Financial Institution)*

Routing Transit Number	C/S	Depositor Account Number	
			☐ No Account ☐ Direct Deposit Refused

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

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 *(Number and Street, City, State and ZIP Code)*	Address *(Number and Street, City, State and ZIP Code)*

See Revise Privacy Act Statement

The Social Security Administration (SSA) collects the information on this form under sections 202, 205, and 223 of the Social Security Act. The information you provide will be used by SSA to determine if you or a dependent is eligible to insurance coverage and/or monthly benefits. While completion of this form is voluntary, failure to provide all or any part of the requested information may effect our ability to make an accurate and timely decision concerning your entitlement or a dependent's entitlement to benefit payments.

The information you furnish on this form may be disclosed by SSA as generally permitted under 5 U.S.C.§ 522a(b) of the Privacy Act, as amended. This includes using the information: (1) to assist Social Security in establishing the right of an individual to Social Security benefits; (2) to facilitate statistical research and audit activities necessary to assure the integrity and improvement of the Social Security programs; and (3) to comply with Federal laws requiring the release of information from our records.

SSA 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 SSA to do this even if you do not agree to it.

Explanation about reasons why information you provide us may be used or provided to other agencies are available upon request from a Social Security office.

See Revised Paperwork Reduction Act

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 (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.**

RECEIPT FOR YOUR CLAIM FOR SOCIAL SECURITY MOTHER'S OR FATHER'S INSURANCE BENEFITS

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

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 have a change of 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 below.

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 NUMBER

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 _____ (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.
- Change of Marital Status - Marriage, divorce, annulment of marriage. You must report marriage even if you believe that an exception applies.
- Custody Change or Disability Improves - Report if a person for whom you are filing, or who is in your care dies, leaves your care or custody, changes address, or if disabled, the condition improves.
- 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.

WORK AND EARNINGS

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.

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.

SSA will insert the following revised Privacy Act Statement into the form at its next scheduled reprinting:

Privacy Act Notice

Application for Mother's or Father's Insurance Benefits

Sections 202, 205, and 223 of the Social Security Act, as amended, authorize us to collect this information. We will use the information you provide to determine eligibility of you or a dependent for Social Security benefits.

Furnishing us this information is voluntary. However, failure to provide all or part of the information could prevent us from making an accurate and timely decision on your entitlement or a dependent's entitlement to Social Security benefit payments.

We rarely use the information you supply for any purpose other than for making a determination relating to your entitlement or a dependent's entitlement to Social Security benefit payments. 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 and improvement of Social Security programs (e.g., to the Bureau of the Census and private concerns under contract to Social Security).

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.

A complete list of routine uses for this information is available in System of Records Notice entitled, Master Beneficiary Record, 60-0090. This notice, additional information regarding this form, and information regarding our programs and systems, are available on-line at www.socialsecurity.gov or at your local Social Security office.

SSA will insert the following revised PRA Statement 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 (OMB) control number. The OMB control number for this collection is 0960-0555. We estimate that it will take 15 minutes to read the instructions, gather the facts, and answer the questions. ***Send only comments relating to our time estimate above to***: *SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.*