Social Security Administration ☐ TEL TOE 120/145/155 Form Approved OMB No 0960-0012

APPLICATION FOR PARENT'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.

*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.) For additional information about this application a factsheet to Form SSA-7 is available at www.socialsecurity.gov

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. →	__ __ __ / __ __ /__ __ __ __
	(c)	Enter your name at birth if different from item 2(a). →	
3.	(a)	Were you receiving at least one-half of your support from the Deceased at the time the Deceased became disabled under the Social Security law or at the time of death? →	☐ Yes *(If "Yes," answer (b).)* ☐ No *(If "No," go on to item 4.)*
	(b)	Have you filed proof of this support with the Social Security Administration? →	☐ Yes ☐ No

PART I -- INFORMATION ABOUT THE DECEASED

4.		Enter date of birth of Deceased. →	MONTH, DAY, YEAR
5.	(a)	Enter date of death. →	MONTH, DAY, YEAR
	(b)	Enter place of death. →	CITY AND STATE
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? →	☐ Yes *(If "Yes," answer (b) and (c).)* ☐ No ☐ Unknown *(If "No" or "Unknown" go on to item 7.)*
	(b)	Enter name of person on whose Social Security record other application was filed. →	FIRST NAME, MIDDLE INITIAL, LAST NAME
	(c)	Enter Social Security number of person named in (b), (If "Unknown," so indicate.) →	__ __ __ / __ __ /__ __ __ __

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

7.	(a)	Was the Deceased unable to work because of a disabling condition at the time of death? →	☐ Yes *(If "Yes," answer (b).)* ☐ No *(If "No," go on to item 8.)*
	(b)	Enter date disability began. →	MONTH, DAY, YEAR

8.	(a) Was the Deceased 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? →	☐ Yes *(If "Yes," answer (b) and (c).)*	☐ No *(If "No," go on to item 9.)*
	(b) Enter dates of service. →	From: (Month, year)	To: (Month, year)
	(c) Have you received, or do you expect to receive, a benefit from any other Federal agency? →	☐ Yes	☐ 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 $	☐ Unknown
	(b) About how much did the Deceased earn the year before death? →	AMOUNT $	☐ Unknown
10.	(a) Did the deceased have wages or self-employment income covered under Social Security in all years from 1978 through last year? →	☐ Yes *(If "Yes," skip to item 11.)*	☐ No *(If "No," answer (b).)*
	(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.		

PART II -- INFORMATION ABOUT YOURSELF

12.	(a) Enter your date of birth. →	MONTH, DAY, YEAR		
	(b) 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 13.			
	(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
13.	(a) Have you married since the death of the Deceased?	☐ Yes	☐ No	
	(b) Enter below the information requested about the marriage.			
	To whom married	When *(Month, day, year)*	Where *(Name of City and State)*	
	How marriage ended (If still in effect, write "Not 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)	__ __ __ / __ __ / __ __ __ __		
14.	(a) Have you 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 15.)*	

	(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.)*** →	__ __ __ / __ __ /__ __ __ __
15.		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? →	☐ Yes ☐ No
16.		Did you, your spouse, or the Deceased work in the railroad industry for 5 years or more? →	☐ Yes ☐ No
17.	(a)	Do you have social security credits (for example, based on work or residence) under another country's social security system? →	☐ Yes ***(If "Yes," answer (b).)*** ☐ No ***(If "No," go on to item 18.)***
	(b)	List the country(ies). →	

Answer Item 18 ONLY if the Deceased Died Before This Year.

18.	(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	
19.	(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 earn 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 Not in the Last 4 Months of Your Taxable Year (Sept., Oct., Nov., and Dec., if Your Taxable Year is a Calendar Year).

20.	(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	
21.		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			

MEDICARE INFORMATION

If this claim is approved and you are still entitled to benefits at age 65, or you are within 3 months of age 65 or older you could 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, you will need to contact Social Security to request enrollment.

Complete Item 22 ONLY If You Are Within 3 Months of Age 65 or Older

Medicare Part B (Medical Insurance) helps cover doctor's services and outpatient care. It also covers some other services that Medicare Part A doesn't cover, such as some of the services provided by physical and occupational therapists and some home health care. If you enroll in Medicare Part B, you will have to pay a monthly premium. The amount of your premium will be determined when your coverage begins. In some cases, your premium may be higher based on information about your income we receive from the Internal Revenue Service. Your premiums will be deducted from any monthly Social Security, Railroad Retirement, or Office of Personnel Management benefits you receive. If you do not receive any of these benefits, you will get a letter explaining how to pay your premiums. You will also get a letter if there is any change in the amount of your premium.

You can also enroll in a Medicare prescription drug plan (Part D). To learn more about the Medicare prescription drug plans and when you can enroll visit www.medicare.gov or call 1-800-MEDICARE (1-800-633-4227; TTY 1-877-486-2048). A Medicare Representative can also tell you about agencies in your area that can help you choose your prescription drug coverage.

If you have limited income and resources, we encourage you to apply for the Extra Help that is available to assist you with Medicare prescription drug costs. The Extra Help can pay the monthly premiums, annual deductibles, and prescription co-payments. To learn more or apply, please visit www.socialsecurity.gov, call 1-800-772-1213 (TTY 1-800-325-0778) or visit the nearest Social Security office.

22.	Do you want to enroll in Medicare Part B (Medical Insurance)? → Select "No" if you are already enrolled under your own Social Security Number.	☐ Yes ☐ 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 **(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 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)**

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

See Revised Privacy Act Statement

The Social Security [illegible] authorized to collect the information on this form under sections 202, 205, and 223 of th[illegible]. The information you provide on this form will be used 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.

As permitted under 5 U.S.C. § 552a(b) of the Privacy Act, as amended, SSA may disclose the information you provide (1) to another Federal, State or local government agency for determining eligibility for a government benefit or program; (2) to a Congressional office requesting information on your behalf; (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 ensure the integrity of SSA programs.

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.

Explanations about these and other reasons why information you provide us 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 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 PARENT'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	SOCIAL SECURITY CLAIM NUMBER

DECEASED'S NAME *(If surname differs from name of claimant)*

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 _____ to be $ _____.

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

  You ☐ (are) ☐ (are not) self-employed rendering substantial services in a 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 - Report if a person for whom you are filing, or who is in your care dies, leaves your care or custody, or changes address.

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:

Sections 202(h), 205(a), and 223(d) of the Social Security Act authorize us to collect the information on this form. We will use the information you provide on this form to determine if you or a dependent is eligible to insurance coverage and/or monthly benefits. Your response to this request is voluntary. However, failure to provide all or part of the information could prevent us from making an accurate and timely decision concerning your entitlement or a dependent's entitlement to benefit payments.

We rarely use the information you supply for any purpose other than for determining your living arrangements. 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 Special Veterans Benefits; (2) to comply with Federal laws requiring the release of information from Social Security records (e.g., to the 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.socialsecurity.gov or at any 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 0960-0012. 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.*