Form Approved
OMB No. 0960-0073

REPORTING CHANGES THAT AFFECT YOUR SOCIAL SECURITY PAYMENT

USE THIS FORM WHEN THERE IS A CHANGE TO BE REPORTED. ONLY COMPLETE THE ITEM(S) THAT HAVE CHANGED.

PRINT NAME OF PERSON OR PERSONS ABOUT WHOM REPORT IS MADE

▶

SOCIAL SECURITY CLAIM NUMBER ON WHICH BENEFITS ARE PAID — LETTER

You should include the letter or letter and number A, B, B2 C, C1, D, E, F, or H.

Your report cannot be processed without the correct claim number.

▶ ___ ___ ___ | ___ ___ | ___ ___ ___ ___

▶ DO YOU GET SSI BENEFITS? *(Check one)* ☐ YES ☐ NO

1. ☐ CHANGE OF ADDRESS *(Print new address at bottom)*
   If Social Security sends your payments to your financial organization, do you want this to continue? ☐ YES ☐ NO

2. ☐ WORKING AND WILL EARN OVER THE EXEMPT AMOUNT FOR 2009?
   If you attain full retirement age (FRA) in 2009, your exempt amount is $37,680 ($3,140 a month) for the months before the month you attain FRA. If you attain FRA in 2010 or later, your exempt amount is $14,160 ($1,180).
   a. I am working for wages of more than $1,180 a month (under FRA in 2009) or $3,140 a month (if year of FRA attainment) or performing substantial services in self-employment beginning with the month of_______
   b. I estimate that my total earnings for this taxable year will be ____________
   COMPLETE BOTH BOXES
   2a) MONTH AND YEAR
   2b) AMOUNT $

3. ☐ STOPPING WORK OR LIMITING EARNINGS:
   a. The last month I worked for wages of more than $1,180 (under FRA in 2009) or $3,140 (if year of FRA attainment) or performed substantial services in self-employment was ______________________________
   b. I estimate that my total earnings for this taxable year will be ____________
   COMPLETE BOTH BOXES
   3a) MONTH AND YEAR
   3b) AMOUNT $

4. ☐ CHANGE IN ESTIMATE:
   I estimate that my total earnings for this taxable year will be → AMOUNT $

5. ☐ CHECK if you are self-employed, an officer of a corporation, or related to an officer of a corporation. → ☐

6. ☐ DEATH — DATE OF DEATH:

7. ☐ DIVORCE — DATE OF DIVORCE:

8. ☐ ANNULMENT — DATE OF ANNULMENT:

9. ☐ MARRIAGE *(Place of Marriage) (City, County & State)* | DATE OF MARRIAGE (MO., DAY, YR.) | PRINT NEW LAST NAME

   CHECK if spouse is now receiving Social Security benefits ▶ ☐

   IF SPOUSE RECEIVES SOCIAL SECURITY BENEFITS, FILL IN SPOUSE'S NAME | SPOUSE'S CLAIM NUMBER ___ ___ ___ | ___ ___ | ___ ___ ___ ___ | LETTER ______

10. ☐ GOING OUTSIDE THE U.S. FOR 30 CONSECUTIVE DAYS OR LONGER ▶ | NAME OF COUNTRY TO WHICH GOING | DATE GOING | DATE EXPECT TO RETURN

11. ☐ CHILD OR OTHER CLAIMANT FOR WHOM YOU RECEIVE BENEFITS IS NO LONGER IN YOUR CARE OR OTHERWISE CHANGED ADDRESS. | DATE LEFT YOUR CARE

12. ☐ CONFINEMENT OR IMPRISONMENT
    Confinement in a jail, prison, or other penal institution or correctional facility, based on a conviction. Confinement in an institution by court order as a result of certain criminal cases. → DATE OF CONFINEMENT (MONTH, DAY, YEAR)

13. ☐ GOVERNMENT PENSION OR ANNUITY
    a. I began receiving a government pension or annuity from the Federal government or any State or any political subdivision or my present payments have changed beginning with the month of ______________________
    b. The amount of government pension or annuity I receive is or has been changed to ___
    COMPLETE BOTH BOXES
    13a) MONTH AND YEAR
    13b) MONTHLY AMOUNT $

14. ☐ RECEIPT OF A PENSION OR ANNUITY BASED ON MY EMPLOYMENT AFTER 1956 NOT COVERED BY SOCIAL SECURITY, OR MY PENSION OR ANNUITY, STOPPED. →

BEGINNING DATE	ENDING DATE
MONTH/YEAR	MONTH/YEAR

SIGNATURE OF PERSON MAKING THIS REPORT ▶ | DATE SIGNED

NUMBER AND STREET, APARTMENT NO., P.O. BOX, OR RURAL ROUTE | IS THIS A NEW ADDRESS? ☐ Yes ☐ No | NAME OF COUNTRY, IF ANY, IN WHICH YOU LIVE

CITY, STATE | ZIP CODE | TELEPHONE NUMBER WHERE WE CAN REACH YOU *(INCLUDE AREA CODE)*

HOW TO REPORT

There are three ways to report:

1. **PHONE** Social Security and explain the change.

   Telephone Number (_____) _____
   (Area Code)

2. **VISIT** Social Security

3. **MAIL** this form to Social Security. Make sure you fill in:

   - NA**ME** of person(s) the report is about
   - The correct **CLAIM NUMBER** under which the benefits are payable
   - Whether the person(s) also receives **SSI** or **Black Lung** benefits.
   - **WHAT** is being reported
   - **DATE** it happened
   - Your **SIGNATURE** and **ADDRESS**

If you mail your report, please use this reporting form and send it to the nearest Social Security office.

NOTE: REMEMBER TO TELL US WHEN YOU MOVE, EVEN IF YOUR MAILING ADDRESS FOR CHECKS HAS NOT CHANGED.

WHAT TO REPORT

The law Sections 202, 203, and 205 of the Social Security Act, as amended (42 United States Code 402, 403, and 405.) required you to promptly report certain changes in your circumstances which could affect your continuing eligibility to benefits or your benefit amount. The kinds of changes you must report to Social Security are listed on the reverse side of this form. The booklet, "Your Social Security Rights and Responsibilities, "tells more about reporting changes. If you do not have this booklet or if you want help in making a report, get in touch with any Social Security office. The people there will be glad to help you.

FAILURE TO REPORT

If you do not report changes in your circumstances, you may not be paid some, or all, of the benefits due you. Or, you may be overpaid, in which case, you will have to pay back any benefits you received that were not due you.

If you hide or do not report a change with the intent to fraudulently get more benefits or benefits not due you, you may be fined, imprisoned, or both per Section 208 of the Social Security Act.

PRIVACY ACT STATEMENT

Collection and Use of Personal Information

Sections 202, 203, and 205 of the Social Security Act, as amended (42 U.S.C. 402, 403, and 405) authorizes us to collect this information. We will use the information you provide to assist us in determining your continuing eligibility to benefits or your benefit amount. The information you provide on this form is voluntary. However, failure to provide all or part of the requested information could prevent us from making an accurate and timely decision on your claim or could result in the loss of benefits.

We rarely use the information you provide on this form for any purpose other than for the reasons explained above. 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, General Services Administration, National Archives Records Administration, and 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.

A complete list of routine uses for this information is available in our System of Records Notice entitled, Claims Folder System, 60-0089. 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.

PAPERWORK REDUCTION ACT

Paperwork Reduction Act Statement - This information collection meets the clearance requirements of 44 U.S.C. §3507, as amended by Section 2 of the Paperwork Reduction Act of 1995. You are 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 5 minutes to read the instructions, gather the necessary 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.***

Use this form only when there is a change to report to Social Security