Social Security Administration ☐ TEL TOE 120/145/155 Form Approved OMB No. 0960-0010

APPLICATION FOR CHILD'S INSURANCE BENEFITS

(Do not write in this space)

I apply on behalf of the child or children listed in item 3 below for all insurance benefits for which they may be eligible under Title II (Federal Old-Age, Survivors and Disability Insurance) of the Social Security Act, as presently amended. (If you are applying on your own behalf, answer the questions on this form with respect to yourself.)

If you are applying for benefits based on the earnings record of a Deceased Worker, 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).

LIFE CLAIM ☐ DEATH CLAIM ☐

1.	(a) PRINT name of Wage Earner or Self-Employed person (herein referred to as the "Worker"). ⟶	FIRST NAME, MIDDLE INITIAL, LAST NAME
	(b) PRINT Worker's Social Security number. ⟶	___ ___ ___ / ___ ___ /___ ___ ___ ___
2.	(a) PRINT your name (unless you are the Worker). ⟶	FIRST NAME, MIDDLE INITIAL, LAST NAME
	(b) PRINT your Social Security number. ⟶	___ ___ ___ / ___ ___ /___ ___ ___ ___

PART I-INFORMATION ABOUT THE WORKER'S CHILDREN

3. The Worker's children (including natural children, adopted children, and stepchildren) or dependent grandchildren (including stepgrandchildren) may be eligible for benefits based on the earnings record of the Worker. For a living Worker, the information below applies to this month or to any of the past 12 months. For a deceased Worker, the information below applies to the date of death or for any period since the Worker's death.

LIST BELOW ALL SUCH CHILDREN (IN ORDER OF BIRTH BEGINNING WITH THE OLDEST) who are now, or who were at the appropriate time (above), UNMARRIED and: • UNDER AGE 18 • AGE 18 TO 19 AND ATTENDING ELEMENTARY OR SECONDARY SCHOOL FULL-TIME • DISABLED OR HANDICAPPED (age 18 or over and disability began before age 22)	Check (X) Sex of Child		Date of Birth (Mo., day, yr.)	Check (X) if Child 17 or Older is:		Check (X) the Column That Shows Child's Relationship to Worker					CHILD'S SOCIAL SECURITY NUMBER
	M	F		Student	Disabled	Legitimate	Adopted	Stepchild	Dependent Grandchild	Other	
FULL NAME OF CHILD											___ ___ ___ / ___ ___ /___ ___ ___ ___
											___ ___ ___ / ___ ___ /___ ___ ___ ___
											___ ___ ___ / ___ ___ /___ ___ ___ ___
											___ ___ ___ / ___ ___ /___ ___ ___ ___
											___ ___ ___ / ___ ___ /___ ___ ___ ___
											___ ___ ___ / ___ ___ /___ ___ ___ ___

If you do not wish to be payee for any child or dependent grandchild named above, list the child's name and address in "Remarks" on page 5. You may apply for a child even though you do not wish to be payee for the child's benefits.

4.	If any children in item 3 are stepchildren of the Worker, enter the date the Worker married the natural parent. ⟶	MONTH, DAY, YEAR
5.	(a) Is there a legal representative (guardian, conservator, curator, etc.) for any of the children in item 3? ⟶	☐ Yes (If "Yes," complete (b) and (c).) ☐ No (If "No," go on to item 6.)

	(b) Write the following information about the legal representative(s):	NAME *(First name, middle initial, last name)*	TELEPHONE NUMBER (INCLUDE AREA CODE)
		ADDRESS	
	(c) Briefly explain the circumstances which led the court to appoint a legal representative.		

6.	Are you the natural or adoptive parent of the person(s) for whom you are filing?	☐ Yes	☐ No
7.	Have any children in item 3 ever been adopted by someone other than the Worker? (If "Yes," enter the following information): →	☐ Yes	☐ No

Name of Child	Date of Adoption	Name of Person Adopting

8.	Are all the children in item 3 now living in the same household with you? (If "No," enter the following information about each child not living with you. If uncertain as to the whereabouts of any of these children, explain in "Remarks".) →	☐ Yes	☐ No

Name of Child Not Living With You	Person With Whom Child Now Lives	
	Name and Address	*Relationship to Child*

9.	Has any child in item 3 ever been married? *(If "Yes," enter the information requested below.)* →	☐ Yes	☐ No
	Name of Child	Date of Marriage (Month, day, year)	
	How Marriage Ended (If still married, write "not ended").	Date Marriage Ended (Month, day, year)	

10.	Has anyone ever before filed an application with the Social Security Administration for monthly benefits on behalf of any child in item 3? (If "Yes," enter below the name(s) of the child(ren) and the name(s) and Social Security number(s) of the person(s) on whose earnings record any other claim was based.) →	☐ Yes	☐ No

Name of Child	Name of Worker	Social Security Number of Worker
		___/___/____
		___/___/____
		___/___/____
		___/___/____

If you are applying ONLY for a child age 18 or over who is disabled, omit items 11 through 14. In all other cases, answer items 11 through 14.

EARNINGS INFORMATION FOR LAST YEAR (Do not complete if the Worker died this year)

11. (a) Did any child in item 3 earn more than the exempt amount last year? *(If "Yes," answer (b). If "No," go on to item 12.)* → ☐ Yes ☐ No

(b) NAME OF CHILD WHO EARNED OVER THE EXEMPT AMOUNT LAST YEAR	TOTAL EARNINGS OF CHILD	LIST EACH MONTH THAT CHILD DID NOT EARN MORE THAN $ _____ IN WAGES AND DID NOT PERFORM SUBSTANTIAL SERVICES IN SELF-EMPLOYMENT
	$	
	$	
	$	

EARNINGS INFORMATION FOR THIS YEAR

12. (a) Do you expect the total earnings of any child in item 3 to be more than the exempt amount this year? (Count all earnings beginning with the first of this year and all anticipated earnings through the end of this year.) (If "Yes," answer (b). If "No," go on to item 13.) → ☐ Yes ☐ No

(b) NAME OF CHILD WHO EXPECTS TO EARN OVER THE EXEMPT AMOUNT THIS YEAR	EXPECTED EARNINGS OF CHILD	LIST EACH MONTH (INCLUDING THE PRESENT MONTH) THAT CHILD DID NOT OR WILL NOT EARN MORE THAN $ _____ IN WAGES AND DID NOT OR WILL NOT PERFORM SUBSTANTIAL SERVICES IN SELF-EMPLOYMENT
	$	
	$	
	$	

Complete item 13 ONLY if any child is now in the last 4 months of the child's taxable year (Sept., Oct., Nov., and Dec., if the taxable year is a calendar year).

EARNINGS INFORMATION FOR NEXT YEAR

13. (a) Do you expect the total earnings of any child in item 3 to be more than the exempt amount next year? (If "Yes," answer (b.) If "No," go on to item 14.) → ☐ Yes ☐ No

(b) NAME OF CHILD WHO EXPECTS TO EARN OVER THE EXEMPT AMOUNT NEXT YEAR	EXPECTED EARNINGS OF CHILD	LIST EACH MONTH THAT CHILD WILL NOT EARN MORE THAN $ _____ IN WAGES AND WILL NOT PERFORM SUBSTANTIAL SERVICES IN SELF-EMPLOYMENT
	$	
	$	
	$	

14. If any of the children for whom you are filing uses a fiscal year (one that does not end on December 31), print here the name of the child and the month the fiscal year ends. → NAME OF CHILD AND MONTH FISCAL YEAR ENDS

Complete items 15 and 16 ONLY if the Worker is living. Otherwise, go on to item 17.

15. If any children in item 3 are children adopted by the Worker, print below the name of each such child and the date of adoption by the Worker.

NAME OF ADOPTED CHILD	DATE OF ADOPTION

16.	Have all of the children in item 3 lived with the Worker during each of the last 13 months (counting the present month)? ⟶ (If "No," enter the information requested below.)		☐ Yes	☐ No
	NAME OF CHILD WHO DID NOT LIVE WITH THE WORKER IN EACH OF THE LAST 13 MONTHS	LIST EACH MONTH IN WHICH THIS CHILD DID NOT LIVE WITH THE WORKER	PERSON WITH WHOM CHILD LIVED	
			NAME AND ADDRESS	RELATIONSHIP TO CHILD

Answer items 17 and 18 only if the child is age 13 or over as of the date of this application.

17.	Do any of the children in item 3 have an unsatisfied felony warrant for his/her arrest? ⟶	☐ Yes	☐ No
18.	Do any of the children in item 3 have an unsatisfied Federal or State warrant for his/her arrest for violating the conditions of his/her probation or parole? ⟶	☐ Yes	☐ No
19.	If any of the children in item 3 are within 2 months of age 65 or older, blind or disabled, do you want to file on his/her behalf for Supplemental Security Income? ⟶	☐ Yes	☐ No

PART II-INFORMATION ABOUT THE DECEASED. Complete items 20 through 28 only if the Worker is deceased.

20.	(a) Print date of birth of Worker ⟶	MONTH, DAY, YEAR	
	(b) Print Worker's name at birth if different from item 1 (a) ⟶		
	(c) Check (X) one for the Worker ⟶	☐ Male	☐ Female
21.	(a) Print date of death ⟶	MONTH, DAY, YEAR	
	(b) Print place of death ⟶	CITY AND STATE	
22.	Print the name of the state or foreign country where the Worker had a fixed, permanent home at the time of death. ⟶	STATE OR FOREIGN COUNTRY	
23.	Did the Worker work in the railroad industry for 5 years or more? ⟶	☐ Yes	☐ No
24.	(a) Was the Worker 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 25.)
	(b) Enter dates of service ⟶	FROM (month -year)	TO (month -year)
	(c) Has anyone (including the Worker) received, or does anyone expect to receive, a benefit from any other Federal agency? ⟶	☐ Yes	☐ No
25.	(a) Did the worker 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 26.)
	(b) List the country(ies). ⟶		
26.	(a) Did the worker have wages or self-employment income covered under Social Security in all years from 1978 through last year? ⟶	☐ Yes (If "Yes," skip to item 27.)	☐ No (If "No," answer (b).)
	(b) List the years from 1978 through last year in which the worker did not have wages or self-employment income covered under Social Security. ⟶		

Answer item 27 ONLY if death occurred within the last 2 years.

27.	(a) About how much did the Worker earn from employment and self-employment during the year of death? ⟶	AMOUNT $
	(b) About how much did the Worker earn the year before death? ⟶	AMOUNT $

28. 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.

29.	(a) Did the Worker 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 ☐ No ☐ Unknown (If "Yes," answer (b) and (c).) (If "No" or "Unknown," go on to item 30.)
	(b) Enter name of person(s) on whose Social Security record other application was filed. ⟶	
	(c) Enter Social Security number of person named in (b). (If "Unknown," so indicate.) ⟶	___ ___ ___ / ___ ___ / ___ ___ ___ ___

Answer item 30 ONLY if the Worker died prior to age 66 and within the past 4 months.

30.	(a) Was the Worker unable to work because of a disabling condition at the time of death? ⟶	☐ Yes ☐ No (If "Yes," answer (b).)
	(b) Enter date disability began ⟶	MONTH, DAY, YEAR
31.	Were all the children in item 3 living with the Worker at the time of death? (If "No," enter the following information) ⟶	☐ Yes ☐ No

NAME OF CHILD NOT LIVING WITH THE WORKER	PERSON WITH WHOM CHILD WAS LIVING	
	NAME AND ADDRESS	RELATIONSHIP TO CHILD

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

Con't 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 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 NUMBERS(S) AT WHICH YOU MAY BE CONTACTED DURING THE DAY (INCLUDE AREA CODE) — — — (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 Revised Privacy Act Statement

Privacy Act Statement - Collection and Use of Personal Information

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 if you or a dependent are eligible for insurance coverage and/or monthly benefits.

The information you furnish on this form is voluntary. However, failure to provide the requested information may prevent us from making an accurate and timely decision concerning your or a dependent's entitlement to benefit payments.

We rarely use the information you supply for any purpose other than for determining the identity of a spouse. 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 enable a third party or an agency to assist Social Security in establishing rights to Social Security benefits and/or coverage, 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), to make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level, and to facilitate statistical research and audit 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.

Additional information regarding this form, routine uses of information, and our programs and systems, is available on-line at www.socialsecurity.gov or at your local Social Security office.

See Revised Paperwork Reduction Act Statement

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 to 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 CHILD'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 on behalf of the child(ren) named below has been received. You will be notified by mail as soon as a decision is made on your claim.

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 or any child(ren) changes 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

WORKER'S NAME *(If surname differs from name of claimant(s).)*

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 or any child changes 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.)*
- Any child's citizenship or immigration status changes.
- Any beneficiary goes 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

  _____ (Name of Child) expected total earnings for _____

  to be $_____ .

  _____ (Name of Child) ☐ (is) ☐ (is not) earning wages of

  more than $ _____ a month.

  _____ (Name of Child) ☐ (is) ☐ (is not) self-employed

  rendering substantial services in a trade or business.

  (Report AT ONCE if this work pattern changes.)
- Custody Change - Report if a child for whom you are filing or who is in your care dies, leaves your care or custody, or changes address.
- The child age 13 or older has an unsatisfied warrant for their arrest for a crime or attempted crime that is a felony (or in jurisdictions that do not define crime as felonies, a crime that is punishable by death or imprisonment for a term exceeding 1 year).
- The child age 13 or older has an unsatisfied warrant for a violation of probation or parole under Federal or State law.
- A student, age 18 or over, stops attending school, reduces school attendance below full-time, changes schools, or is paid by an employer to attend school.
- If the worker and stepchild's parent divorce. Benefits are not payable to a stepchild beginning with the month after the month the worker and the stepchild's parent divorce. Promptly return any benefit payment received on behalf of the stepchild for the months after the month the divorce becomes final.
- The child is confined to jail, prison, penal institution or correctional facility for conviction of a crime or confined to a public institution by court order in connection with a crime.
- Change of Marital Status- Marriage, divorce, or annulment of marriage. You must report marriage even if you believe that an exception applies.
- Disability Applicants

  In addition to the applicable reporting requirements listed above:

  1. The disabled adult child returns to work (as an employee or self-employed) regardless of amount of earnings.
  2. The disabled adult child's condition improves.

  An agency in your State that works with us in administering the Social Security disability program is responsible for making the disability decision on the child's claim. In some cases, it is necessary for them to get additional information about the child's condition or to arrange for the child to have a medical examination at Government expense.

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:

- Visiting the section "What You Can Do Online" at our web site at www.socialsecurity.gov;
- 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 above.

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 the child earns more than the annual exempt amount. You may contact SSA to file a report for the child. Otherwise, SSA will use the earnings reported by the child's employer(s) and the child's 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 the child's earnings is correct.

Application for Child's Insurance Benefits, form SSA-4-BK
Privacy Act Statement
Collection and Use of Personal Information

Sections 202, 205, and 223 of the Social Security Act as amended, [42 U.S.C. 402, 405, and 423] authorizes us to collect this information. We will use the information you provide to help us determine if you or a dependent are eligible for insurance coverage and/or monthly benefits. The information you provide on this form is voluntary. However, failure to provide the requested information may prevent us from making an accurate and timely decision concerning you or a dependent's entitlement to benefit payments.

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 on 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 for 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 agencies 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 Systems of Records Notices entitled, Claims Folder System, 60-0089 and Medicare Database (MDB) File, 60-0321. The notices, additional information regarding this form, and information regarding our system and programs, are 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 control number. We estimate that it will take about 12 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY 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 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.***