

# SOCIAL SECURITY

Refer to:

•

Date:

Social Security  
Number

Worker's Name:

Telephone:  
Area Code:

So that we may determine the above-named person's eligibility for Social Security benefits, please furnish the amount of gross wages earned by the employee in each of the months checked below. If no wages were earned in a month, show "none."

Please note that we need to know the amounts earned for services performed within the calendar month, regardless of the amounts paid. If the employee received cash tips, include the amount in the totals for the month.

We appreciate your cooperation in furnishing this information. An envelope requiring no postage is enclosed for your convenience.

Sincerely yours,

Enclosure

Year	If the amount of wages for each month is the same, enter the monthly amount here. \$ _____		
<input type="checkbox"/> January \$ _____ <input type="checkbox"/> February _____ <input type="checkbox"/> March _____	<input type="checkbox"/> April \$ _____ <input type="checkbox"/> May _____ <input type="checkbox"/> June _____	<input type="checkbox"/> July \$ _____ <input type="checkbox"/> August _____ <input type="checkbox"/> September _____	<input type="checkbox"/> October \$ _____ <input type="checkbox"/> November _____ <input type="checkbox"/> December _____

See other side for additional years *(check if applicable)*.

**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.**

EMPLOYER		AREA CODE AND TELEPHONE NO.
NAME	TITLE	DATE

Year \_\_\_\_\_

If the amount of wages for each month is the same, enter the monthly amount here. \$ \_\_\_\_\_

<input type="checkbox"/> January \$ _____	<input type="checkbox"/> April \$ _____	<input type="checkbox"/> July \$ _____	<input type="checkbox"/> October \$ _____
<input type="checkbox"/> February _____	<input type="checkbox"/> May _____	<input type="checkbox"/> August _____	<input type="checkbox"/> November _____
<input type="checkbox"/> March _____	<input type="checkbox"/> June _____	<input type="checkbox"/> September _____	<input type="checkbox"/> December _____

Year \_\_\_\_\_

If the amount of wages for each month is the same, enter monthly amount here. \$ \_\_\_\_\_

<input type="checkbox"/> January \$ _____	<input type="checkbox"/> April \$ _____	<input type="checkbox"/> July \$ _____	<input type="checkbox"/> October \$ _____
<input type="checkbox"/> February _____	<input type="checkbox"/> May _____	<input type="checkbox"/> August _____	<input type="checkbox"/> November _____
<input type="checkbox"/> March _____	<input type="checkbox"/> June _____	<input type="checkbox"/> September _____	<input type="checkbox"/> December _____

Year \_\_\_\_\_

If the amount of wages for each month is the same, enter monthly amount here. \$ \_\_\_\_\_

<input type="checkbox"/> January \$ _____	<input type="checkbox"/> April \$ _____	<input type="checkbox"/> July \$ _____	<input type="checkbox"/> October \$ _____
<input type="checkbox"/> February _____	<input type="checkbox"/> May _____	<input type="checkbox"/> August _____	<input type="checkbox"/> November _____
<input type="checkbox"/> March _____	<input type="checkbox"/> June _____	<input type="checkbox"/> September _____	<input type="checkbox"/> December _____

Year \_\_\_\_\_

If the amount of wages for each month is the same, enter monthly amount here. \$ \_\_\_\_\_

<input type="checkbox"/> January \$ _____	<input type="checkbox"/> April \$ _____	<input type="checkbox"/> July \$ _____	<input type="checkbox"/> October \$ _____
<input type="checkbox"/> February _____	<input type="checkbox"/> May _____	<input type="checkbox"/> August _____	<input type="checkbox"/> November _____
<input type="checkbox"/> March _____	<input type="checkbox"/> June _____	<input type="checkbox"/> September _____	<input type="checkbox"/> December _____

**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.**

NAME	TITLE	DATE
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**Privacy Act Statement Collection and  
Use of Personal Information**

**Sections 205(a), 205(c)(2), and 233 of the Social Security Act, as amended, the Federal Records Act of 1950 (64 Stat. 583), the Employee Retirement Income Security Act of 1974 (Pub. L. 93-406), the Coal Industry Retiree Health Benefit Act of 1992 (Pub. L. 102-486, 106 Stat. 2776) and our regulations at 20 CFR 404.703, authorize us to collect this information. We will use the information to determine your employee's eligibility for Social Security Benefits.**

The information you furnish on this form is voluntary. However, we need your cooperation to assure that the above-named person's wage record is accurate and that we can correctly determine eligibility for Social Security benefits.

We rarely use the information you supply for any purpose other than for determining continued eligibility. 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 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.

**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. The OMB control number for this collection is 0960-0034. We estimate that it will take about 40 minutes to read the instructions, gather the facts, and answer the questions. ***Send only comments relating to our time estimate to : SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.***