SOCIAL SECURITY ADMINISTRATION ☐ TEL TOE 120/145 Form Approved OMB No. 0960-0618

APPLICATION FOR DISABILITY INSURANCE BENEFITS

(Do not write in this space)

I apply for a period of disability and/or all insurance benefits for which I am eligible under Title II and Part A of Title XVIII of the Social Security Act, as presently amended.

1.	**PRINT your name**	FIRST NAME, MIDDLE INITIAL, LAST NAME
2.	Enter your Social Security Number	
3.	Check (X) whether you are	☐ Female ☐ Male

Answer question 4 if English is not your preferred language. Otherwise, go to item 5.

4.	Enter the language you prefer to: speak _____	write _____
5.	(a) Enter your date of birth	
	(b) Enter name of city and state or foreign country where you were born.	
	(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
6.	(a) Are you a U.S. citizen?	☐ Yes (If "Yes," go to item 7) ☐ No (If "No," answer (b))
	(b) Are you an alien lawfully present in the U.S.?	☐ Yes (If "Yes," answer (c)) ☐ No (If "No," go to item 7)
	(c) When were you lawfully admitted to the U.S.?	
7.	(a) Enter your name at birth if different from item (1)	
	(b) Have you used any other names?	☐ Yes (If "Yes," answer (c)) ☐ No (If "No," go to item 8)
	(c) Other name(s) used.	
8.	(a) Have you used any other Social Security number(s)?	☐ Yes (If "Yes," answer (b)) ☐ No (If "No" go to item 9)
	(b) Enter Social Security number(s) used.	
9.	When do you believe your condition(s) became severe enough to keep you from working (even if you have never worked)?	
	(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 ☐ Unknown (If "No," or "Unknown," go to item 11)
	(b) Enter name of person on whose Social Security record you filed the other application.	
	(c) Enter Social Security Number of person named in (b). *If unknown, check this block.* ☐ Unknown	

11.	**(a) 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 (If "Yes," answer (b) and (c))	☐ No (If "No," go to item 12)
	(b) Enter dates of service	FROM: (Month, Year)	TO: (Month, Year)
	(c) Have you ever been (or will you be) eligible for a monthly benefit from a military or civilian Federal agency? (Include Veteran's Administration benefits only if you waived military retirement pay.)	☐ Yes	☐ No
12.	**Did you or your spouse (or prior spouse) work in the railroad industry for 5 years or more?**	☐ Yes	☐ No
13.	**(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 to item 14)
	(b) List the country(ies):		
14.	**(a) Are you entitled to, or do you expect to be entitled to, a pension or annuity (or a lump sum in place of a pension or annuity) based on your work after 1956 not covered by Social Security?**	☐ Yes (If "Yes," answer (b) and (c))	☐ No (If "No," go to item 12)
	(b) ☐ I became entitled, or expect to become entitled, beginning	**MONTH**	**YEAR**
	(c) ☐ I became eligible, or expect to become eligible, beginning	**MONTH**	**YEAR**

I AGREE TO PROMPTLY NOTIFY the Social Security Administration if I become entitled to a pension or annuity based on my employment not covered by Social Security, or if such pension or annuity stops.

15.	**(a) Have you ever been married?**	☐ Yes (If "Yes," answer (b))	☐ No If "No," go to item 16)

(b) Give the following information about your current marriage. If not currently married, write "None." _____ (If "None," go on to item 15(c))

Spouse's name (including maiden name)		**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)**		**Spouse's Social Security Number (If none or unknown, so indicate)**

(c) Enter information about any other marriage if you:

- **Had a marriage that lasted at least 10 years; or**
- **Had a marriage that ended due to the death of your spouse, regardless of duration; or**
- **Were divorced, 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. If none, write "None." _____ Go on to item 15(d) if you have a child(ren) who is under age 16 or disabled or handicapped (age 16 or over and disability began before age 22) and you are divorced from the child's other parent who is now deceased and the marriage lasted less than 10 years.**

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 spouse's death**	**Spouse's Social Security Number (If none or unknown, so indicate)**

(d) Enter information about any marriage if you:

- **Have a child(ren) who is under age 16 or disabled or handicapped (age 16 or over and disability began before age 22); and**
- **Were married for less than 10 years to the child's mother or father, who is now deceased; and**
- **The marriage ended in divorce**

If none, write "None." _____

Spouse's name (including maiden name)		**When (Month, day, year)**	**Where (Name of City and State)**
Date of divorce (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 spouse's death**	**Spouse's Social Security Number (If none or unknown, so indicate)**

Use the "REMARKS" space on page 5 for marriage continuation or explanation.

16. If your claim for disability benefits is approved, your children (including adopted children, and stepchildren) or dependent grandchildren (including stepgrandchildren) may be eligible for benefits based on your earnings record.

List below: FULL NAME OF ALL such children who are now or were in the past 12 months 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)

17. (a) Did you have wages or self-employment income covered under Social Security in all years from 1978 through last year? ☐ Yes (If "Yes," go to item 18) ☐ No (If "No," answer (b))

(b) List the years from 1978 through last year in which you did not have wages or self-employment income covered under Social Security.

18. Enter below the names and addresses of all the persons, companies, or Government agencies for whom you have worked this year and last year. IF NONE, WRITE "NONE" BELOW AND GO TO ITEM 19.

NAME AND ADDRESS OF EMPLOYER (If you had more than one employer, please list them in order beginning with your last (most recent) employer)	Work Began		Work Ended (If still working show "Not Ended")	
	MONTH	YEAR	MONTH	YEAR

(If you need more space, use "Remarks".)

19. May the Social Security Administration or State agency reviewing your case, ask your employers for information needed to process the claim? ☐ Yes ☐ No

20. Complete item 20 even if you were an employee.

(a) Were you self-employed this year or last year? ☐ Yes (If "Yes," answer (b)) ☐ No (If "No," go to item 21)

(b) Check the year (or years) you were self-employed	In what type of trade/business were you self-employed? (For example, storekeeper, farmer, physician)	Were your net earnings from the trade or business $400 or more? (Check "Yes" or "No")
☐ This year		
☐ Last year		☐ Yes ☐ No

21. (a) How much were your total earnings last year? Count both wage and self-employment income. (If none, write "None.") _____ Amount $ _____

(b) How much have you earned so far this year? (If none, write "None.") _____ Amount $ _____

22.	(a) Are you still unable to work because of your illnesses, injuries, or conditions?	☐ Yes ☐ No (If "Yes," go to item 23) (If "No," answer (b))
	(b) Enter the date you became able to work.	MONTH, DAY, YEAR
23.	Are your illnesses, injuries, or conditions related to your work in any way?	☐ Yes ☐ No
24.	(a) Have you filed, or do you intend to file, for any other public disability benefits (including workers' compensation, Black Lung benefits and SSI)?	☐ Yes ☐ No (If "Yes," answer (b)) (If "No," to item 25)
	(b) The other public disability benefit(s) you have filed (or intend to file) for is (Check as many as apply): ☐ Veterans Administration Benefits ☐ Welfare ☐ Supplemental Security Income ☐ Other (If "Other," complete a Workers' Compensation/Public Disability Benefit Questionnaire)	
25.	(a) Did you receive any money from an employer(s) on or after the date in item 9 when you became unable to work because of your illnesses, injuries, or conditions? If "Yes", give the amounts and explain in "Remarks".	☐ Yes ☐ No Amount $ _____
	(b) Do you expect to receive any additional money from an employer, such as sick pay, vacation pay, other special pay? If "Yes," please give amounts and explain in "Remarks".	☐ Yes ☐ No Amount $ _____
26.	Do you, or did you, have a child under age 3 (your own or your spouse's) living with you in one or more calendar years when you had no earnings?	☐ Yes ☐ No
27.	Do you have a dependent parent who was receiving at least one-half support from you when you became unable to work because of your disability? If "Yes," enter the parent's name and address and Social Security number, if known, in "Remarks".	☐ Yes ☐ No
28.	If you were unable to work before age 22 because of an illness, injury or condition, do you have a parent (including adoptive or stepparent) or grandparent who is receiving social security retirement or disability benefits or who is deceased? If yes, enter the name(s) and Social Security number, if known, in "Remarks" (if unknown, check "Unknown").	☐ Yes ☐ No ☐ Unknown

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

I declare under penalty of perjury that I have examined all the information on the form and any accompanying statements or forms, and it is true and correct to the best of my knowledge.

SIGNATURE OF APPLICANT	Date (Month, Day, Year)
Signature (First name, middle initial, last name) (Write in ink)	Telephone Number(s) at which you may be contacted during the day. (Include the area code)

DIRECT DEPOSIT PAYMENT INFORMATION (FINANCIAL INSTITUTION)

Routing Transit Number	Account Number	☐ Checking ☐ Savings	☐ Enroll in Direct Express ☐ 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 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)*

FOR YOUR INFORMATION

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

Privacy Act Statement
Collection and Use of 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, if you fail to provide all or part of the requested information it 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 determining benefit payments for you or a dependent. However, we may use it for the administration and integrity of our 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 us in establishing right to Social Security benefits and/or coverage;
2. To comply with Federal laws requiring the release of information from our 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. (e.g., to the Bureau of Census and to private entities under contract with us).

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 incorrect payments or delinquent debts under these programs.

A complete list of routine uses for this information is available in our Privacy Act Systems of Records Notices entitled, Earnings Recording and Self Employment Income System (60-0059) and Claims Folders Systems (60-0089). Additional information regarding these and other systems of records notices, are available on-line at www.socialsecurity.gov or at your local Social Security office.

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 20 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 21235-0001 .* ***Send only comments relating to our time estimate to this address, not the completed form.***

RECEIPT FOR YOUR CLAIM FOR SOCIAL SECURITY DISABILITY INSURANCE BENEFITS

Person to Contact About Your Claim	SSA OFFICE	Date Claim Received
Telephone Number (Include Area Code)		

Your application for Social Security disability 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 change your 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

CHANGES TO BE REPORTED AND HOW TO REPORT

FAILURE TO REPORT MAY RESULT IN OVERPAYMENTS THAT MUST BE REPAID

- 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.
- 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.
- You are confined to a jail, prison, penal institution or correctional facility for more than 30 continuous days for conviction of a crime, or you are confined for more than 30 continuous days to a public institution by a court order in connection with a crime.
- You become entitled to a pension, an annuity, or a lump sum payment based on your employment not covered by Social Security, or if such pension or annuity stops.
- Your stepchild is entitled to benefits on your record and you and the stepchild's parent divorce. Stepchild benefits are not payable beginning with the month after the month the divorce becomes final.
- You have an unsatisfied warrant for more than 30 continuous days for your arrest for a crime or attempted crime that is a felony of flight to avoid prosecution or confinement, escape from custody and flight-escape. In most jurisdictions that do not classify crimes as felonies, this applies to a crime that is punishable by death or imprisonment for a term exceeding one year (regardless of the actual sentence imposed).
- You have an unsatisfied warrant for more than 30 continuous days for a violation of probation or parole under Federal or State law.
- Change of Marital Status — Marriage, divorce, annulment of marriage.
- If you become the parent of a child (including an adopted child) after you have filed your claim, let us know about the child so we can decide if the child is eligible for benefits. Failure to report the existence of these children may result in the loss of possible benefits to the child(ren).
- You return to work (as an employee or self-employed) regardless of amount of earnings.
- Your condition improves.
- You are under age 65 and you apply for or begin to receive workers' compensation (including black lung benefits) or another public disability benefit, or the amount of your present workers' compensation or public disability benefit changes or stops, or you receive a lump-sum settlement.

HOW TO REPORT

You can make your reports online, 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 "my Social Security" 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 shown on your claim receipt.

For general information about Social Security, visit our web site at www.socialsecurity.gov.