STATEMENT REGARDING MARRIAGE

All questions must be answered or marked "Unknown." If you need more space for answers, continue them under "Remarks" on reverse side.

Print Name of Wage Earner or Self-Employed Person *(Herein referred to as the "Worker".)*	Enter His (Her) Social Security Number

Print Name of Applicant

I understand that this statement will be considered in connection with an application by the applicant named above for payment of benefits under the provisions of Title II of the Social Security Act, as amended, based on the earnings of the Worker named above.

Print Your Full Name *(First name, middle initial, last name)*

1.	What is your relationship to the Worker? *(Mother, child, cousin, etc. - if not related, state "None.")*		
	To the Applicant? *(Mother, child, cousin, etc. - if not related, state "None.")*		
2.	How long have you known the Worker?	The Applicant?	
3.	How often and on what occasions did you meet the Worker?		
	The Applicant?		
4.	To your knowledge, were (are) the Worker and Applicant generally known as husband and wife?	☐ Yes	☐ No
5.	Did (do) you consider them husband and wife?	☐ Yes	☐ No
	Give facts and explain fully the reasons for your belief:		
6.	Did you hear them refer to each as husband and wife?	☐ Yes	☐ No
	If "Yes," when and where?		

7. In your opinion, did (do) they maintain a home and live together as husband and wife? ☐ Yes ☐ No
If "Yes," where and when?

CITY OR TOWN	STATE	DATES	
		FROM	TO

8. To your knowledge, did they live together continuously? ☐ Yes ☐ No
If "No," explain.

9. To your knowledge, has either the Worker or the Applicant entered into any other marriage? ☐ Yes ☐ No
If "Yes, " give the following information regarding all such marriages.

STATE WHETHER WORKER OR APPLICANT	TO WHOM MARRIED	DATE AND PLACE OF MARRIAGE	HOW MARRIAGE TERMINATED	DATE AND PLACE MARRIAGE TERMINATED

Remarks: *(This space may be used for explaining any answers to the questions. 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.

SIGNATURE OF PERSON MAKING STATEMENT

Signature *(First name, middle initial, last name) (Write in ink)*	Date *(Month, day, year)*
	Telephone Number (include Area Code)

Mailing Address *(Number and Street, Apt. No., P.O. Box, or Rural Route)*

City and State	ZIP Code

Witnesses are required ONLY if this statement has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the person making the statement must sign below, giving their full addresses.

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)*

Privacy Act Statement

Collection and Use of Personal Information

Section 216(h)(1)(A) of the Social Security Act, as amended, authorizes us to collect this information. We will use the information you provide to establish an individual's marital relationship and to make an eligibility determination for Social Security benefits.

Furnishing us this information is voluntary. However, failing to provide us with all or part of the information may prevent an accurate and timely decision on any claim filed.

We rarely use the information you supply us for any purpose other than to make a determination regarding benefits eligibility. However, we may use the information for the administration of our programs including sharing information:

1. To comply with Federal laws requiring the release of information from our records (e.g., to the Government Accountability Office and the Department of Veterans Affairs); and,
2. To facilitate statistical research, audit, or investigative activities necessary to ensure the integrity and improvement of our programs (e.g., to the Bureau of the Census and to private entities under contract with us).

A complete list of when we may share your information with others, called routine uses, is available in our Privacy Act System of Records Notices 60-0089, entitled, Claims Folders Systems; and, 60-0320, entitled, Electronic Disability (eDIB) Claim File. Additional information about these and other system of records notices and our programs are available online at www.socialsecurity.gov or at your local Social Security Office.

We may share the information you provide to other health agencies through computer matching programs. Matching programs compare our records with records kept by other Federal, State or local government agencies. We use the information from these programs 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.

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. We estimate that it will take about 9 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.*