SOCIAL SECURITY ADMINISTRATION

Form Approved
OMB No. 0960-0051

SUPPLEMENT TO CLAIM OF PERSON OUTSIDE THE UNITED STATES
(To be completed by or on behalf of person who is, was, or will be outside the U.S.)

For Social Security purposes, a person is outside the United States (U.S.) if he or she is physically outside the 50 States, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, the Northern Mariana Islands, or American Samoa for 30 consecutive days or more.

1. NAME OF WORKER ON WHOSE EARNINGS THIS CLAIM IS BASED	2. WORKER'S SOCIAL SECURITY NUMBER

3. Complete line (a) below for the worker (even if deceased). Complete (b) through (d) for each beneficiary in the same household who is outside the U.S., has been outside the U.S. in the past 24 months, or expects to be outside the U.S. in the next 3 months. If you need more space, use the "REMARKS" section on page 3.

FULL NAME	DATES OUTSIDE THE U.S. FROM Mo-Day-Yr	DATES OUTSIDE THE U.S. TO Mo-Day-Yr	DATES OUTSIDE THE U.S. COUNTRY WHERE LIVING	COUNTRY OF BIRTH	COUNTRY(IES) OF PRESENT CITIZENSHIP (Or at time of death)	PERSON HAS U.S. PASSPORT, LIST: PASSPORT NO.	PERSON HAS U.S. PASSPORT, LIST: DATE ISSUED
a.							
b.							
c.							
d.							

NOTE: All persons listed above and in the "REMARKS" section on page 3, or their representative payees, must sign the certification in item 18.

4. Enter the name of any beneficiary listed in item 3 who is not a U.S. citizen and who will be outside the U.S. in the next 6 months, or who has been outside the U.S. in the past 6 months up to, and including, this month. Do not include residents of Canada or Mexico who are entering the U.S. on a daily basis to work or visit and returning each day to their residence in Canada or Mexico. If you need more space, use the "REMARKS" section on page 3.

FULL NAME	TOTAL NUMBER OF YEARS LIVED IN THE U.S.	DATES LIVED IN THE U.S. FROM Mo-Day-Yr	DATES LIVED IN THE U.S. TO Mo-Day-Yr	RELATIONSHIP TO WORKER NAMED IN ITEM 1 DURING THIS PERIOD	DATES LIVED IN THE U.S. FROM Mo-Day-Yr	DATES LIVED IN THE U.S. TO Mo-Day-Yr	RELATIONSHIP TO WORKER NAMED IN ITEM 1 DURING THIS PERIOD
a.							
b.							
c.							
d.							

5. Has any person listed in item 3 been employed or self-employed outside the U.S. during any of the past 12 months? If "yes," give name(s) and date(s) work began and submit Form SSA-7163 (available at www.socialsecurity.gov). If you need more space, use the "REMARKS" section on page 3. ☐ YES ☐ NO

NAME	Date (Mo - Yr)	NAME	Date (Mo - Yr)

6. Does any person listed in item 3 expect to begin employment or self-employment outside the U.S. in the future? If "yes," give name(s) and date(s) work is expected to begin.If you need more space, use the "REMARKS" section on page 3. ☐ YES ☐ NO

NAME	Date (Mo-Yr)	NAME	Date (Mo - Yr)

7. Answer item 7 only if the worker named in item 1 is deceased.
Did the worker die while in the military service of the U.S. or as a result of disease or injury incurred or made worse while in military service? ☐ YES ☐ NO

8. Supplementary Medical Insurance generally is payable only for medical services provided inside the U.S. If anyone listed in item 3 is now enrolled in Supplementary Medical Insurance under Medicare and wishes to terminate that enrollment, enter his or her name here. If you need more space, use the "REMARKS" section on page 3.

NAME(S)

IF EVERYONE LISTED IN ITEM 3 IS A U.S. CITIZEN, SKIP ITEMS 9 THROUGH 14 AND GO TO ITEM 15.

The U.S. Internal Revenue Code (IRC) requires the Social Security Administration (SSA) to withhold a 30 percent Federal income tax from 85 percent of monthly retirement, survivors and disability benefits paid to beneficiaries who are neither citizens nor residents of the U.S. This results in an effective tax of 25.5 percent of the monthly benefit. SSA must withhold this tax from the benefits of all nonresident aliens except those who are residents of countries that have tax treaties with the U.S. that provide an exemption from this tax, or a lower rate of withholding. Currently these countries are Canada, Egypt, Germany, India, Ireland, Israel, Italy, Japan, Romania, Switzerland, and the United Kingdom. You must check with the Internal Revenue Service (IRS) for the current list.

If you are a U.S. resident alien, your worldwide income generally is subject to U.S. income tax, regardless of where you are living. A person cannot be considered a U.S. resident in any year for which he or she has claimed a tax treaty benefit as a resident of a country other than the U.S.

For Federal income tax purposes, a person can be considered a U.S. resident, even if that person lives outside the U.S., if he or she:

- Has been lawfully admitted to the U.S. for permanent residence, and that residence has not been revoked or determined to have been administratively or judicially abandoned, or
- Meets a substantial presence test as determined by the provisions of the IRC. To meet this test in a given year, the person must be present in the U.S. on at least 31 days in that year, and a minimum total of 183 days counting all days of U.S. presence in that year, one-third of the total number of days of U.S. presence in the previous year, and one-sixth of the total number of days of U.S. presence in the year before that. The days of U.S. presence and exclusions are defined in the IRC.

COMPLETE ITEMS 9 THROUGH 13 ABOUT ALL PERSONS LISTED IN ITEM 3 WHO ARE NOT U.S. CITIZENS AND WANT TO BE CONSIDERED U.S. RESIDENTS FOR INCOME TAX PURPOSES.

9. Enter below the name of all persons listed in item 3 who believe they will have U.S resident status while living outside the U.S. Also show the number of each person's Permanent Resident Card (sometimes referred to as a Green Card) and the date that card was issued. If any person was not lawfully admitted for permanent residence, show "None" and explain why he or she is a U.S. resident in the "REMARKS" section on page 3.

NAME	PERMANENT RESIDENT CARD (GREEN CARD) NUMBER	DATE CARD WAS ISSUED

10. Enter the name(s) of any person(s) listed in item 9 who has ever notified the U.S. government, by letter or formal application, that he or she has abandoned, or wishes to abandon, his or her U.S. residence status, or has commenced to be treated as a resident of a foreign country under the provisions of a tax treaty between the U.S. and the foreign country.

NAME	Date (Mo-Yr)	NAME	Date (Mo-Yr)

11. Enter the name(s) of any person(s) listed in item 9 whose Permanent Resident Card has been taken away, or who has been notified by the U.S government that his or her U.S. resident status has been taken away. Enter the date of the notice or the date the Permanent Resident Card was taken away.

NAME	Date (Mo-Yr)	NAME	Date (Mo-Yr)

12. Does each person listed in item 9 understand that, as a U.S. resident, his or her worldwide income will be subject to U.S. income tax regardless of where he or she is living? If no, enter the name of each individual who does not understand in the "REMARKS" section on page 3. ☐ YES ☐ NO

13. Does each person listed in item 9 agree to notify SSA promptly if he or she abandons his or her U.S. residence status, or if he or she commences to be treated as a resident of a foreign country under the provisions of a tax treaty between the U.S. and the foreign country? If no, enter the name of each individual who does not understand in the "REMARKS" section on page 3. ☐ YES ☐ NO

14. **INCOME TAX TREATY BENEFITS** Complete this item for any person(s) who intend(s) to claim a reduced rate of Federal income tax withholding under the provisions of an income tax treaty with the U.S. To enter additional person(s), use the "REMARKS" section below.

NAME	TAX TREATY COUNTRY OF RESIDENCE	DATES OF RESIDENCE	
		FROM (Mo-Yr)	TO (Mo-Yr)

15. **PAYMENT ADDRESS** (Where payments should be sent while you are abroad. If your payments are, or will be, sent directly to a bank or other financial institution, do not complete this item. Go to item 16.) If more than one address is required, use the "REMARKS" section below and show names for each address.

NUMBER AND STREET	CITY	POSTAL CODE	COUNTRY

16. **MAILING ADDRESS** (Where your mail should be sent while you are abroad. If it is the same as the address in item 15, enter "same as 15" and go to item 17.) If more than one address is required, use the "REMARKS" section below and show names for each address.

NUMBER AND STREET	CITY	POSTAL CODE	COUNTRY

17. **RESIDENCE ADDRESS** (You must complete this item if you live, or will live, at an address other than the address shown in item 15 or 16. If the address where you live, or will live, is the same as the address in item 15 or 16, enter "same as 15 (or 16 if appropriate)" and go to item 18.) If your payments are not, or will not be, sent directly to a bank or other financial institution and you receive, or will receive, them by mail at an address that is not your residence address, explain the reason in "REMARKS" section below.

NAME	NUMBER AND STREET	CITY	POSTAL CODE	COUNTRY
a.				
b.				
c.				
d.				

REMARKS (You may use this space for any additions and explanations. If you are giving information for a particular item on this form, enter the item number in your remark. If you need more space, attach a separate sheet.)

CERTIFICATION AND SIGNATURES

I agree to notify the Social Security Administration promptly if I (or any person for whom I receive benefits) become employed or self-employed while outside the United States, change citizenship, or go (for 30 days or more) to any country other than that indicated in item 17. I also agree to return any payments which are not due.

Under penalties of perjury, I declare that I have examined the information on this form and to the best of my knowledge and belief it is true, correct, and complete. 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.

18.	**SIGNATURE** (FIRST NAME, MIDDLE INITIAL, AND LAST NAME) OF EACH PERSON LISTED IN ITEM 3. REPRESENTATIVE PAYEES MUST SIGN FOR MINORS AND FOR INCAPABLE OR INCOMPETENT ADULTS. Write in ink.	DATE	TELEPHONE NUMBER WHERE YOU MAY BE CONTACTED DURING THE DAY
	a.		
	b.		
	c.		
	d.		

Witnesses are required only if this application has been signed by mark (X) in item 18.
If signed by mark (X), two witnesses who know the signer(s) must sign below, giving their full addresses.

19.	(1) SIGNATURE OF WITNESS			(2) SIGNATURE OF WITNESS		
	ADDRESS (NUMBER AND STREET)			ADDRESS (NUMBER AND STREET)		
	CITY	POSTAL CODE	COUNTRY	CITY	POSTAL CODE	COUNTRY

PRIVACY ACT STATEMENT

Section 202 of the Social Security Act, as amended, and 871 and 1441 of the Internal Revenue Code, allow us to collect this information. We will use the information you provide to determine eligibility for payments of benefits and to determine tax-withholding status.

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

We rarely use the information you supply for any purpose other than what we state above, 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 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 60-0090, entitled Master Beneficiary Record. Additional information about these and other system of records notices and our programs are available from our Internet website 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. The OMB number for this collection is 0960-0051. We estimate that it will take about 10 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 **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) ***Send only comments relating to our time estimate above to: SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.***