

**CLAIM FOR AMOUNTS DUE IN THE CASE OF A DECEASED SOCIAL SECURITY RECIPIENT**

PRINT NAME OF DECEASED	SOCIAL SECURITY NUMBER OF DECEASED _____ - _____ - _____
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If the deceased received benefits on another person's record, print name of that worker _____	NAME OF THE WORKER <b>and/or a Medicare premium refund.</b>
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The deceased may have been due a Social Security payment at the time of death. The Social Security Act provides that amounts due a deceased may be paid to the next of kin or the legal representative of the estate under priorities established in the law. To help us decide who should receive any payment due, please COMPLETE THIS ENTIRE FORM and RETURN it to us in the enclosed envelope.

This claim for the amounts due from the Social Security Administration is being made on behalf of the family or the estate of \_\_\_\_\_ who died on \_\_\_\_\_ day of \_\_\_\_\_ (name of deceased) (month) (year) and who lived in the state of \_\_\_\_\_.

PRINT NAME OF APPLICANT	RELATIONSHIP TO DECEASED (Widow, Son, Legal Representative, etc.)
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**THE FOLLOWING ARE THE NEXT OF KIN OR LEGAL REPRESENTATIVE OF THE DECEASED NAMED ABOVE:**

1.	NAME OF SURVIVING WIDOW(ER) (Please print. If none, state "NONE")	ADDRESS OF SURVIVING WIDOW(ER) (Please print house number, street, apt. number, P.O. Box, rural route, city, state, and ZIP code)
	ENTER SOCIAL SECURITY NUMBER(S) OF WIDOW(ER) NAMED ABOVE. _____	_____ - _____ - _____
	WAS THE WIDOW(ER) NAMED ABOVE LIVING IN THE SAME HOUSEHOLD WITH THE DECEASED AT THE TIME OF DEATH? _____	<input type="checkbox"/> YES If "YES", then SKIP items 2,3,4,5 and SIGN at bottom of page 2. <input type="checkbox"/> NO
	WAS HE OR SHE ENTITLED TO A MONTHLY BENEFIT ON THE SAME EARNINGS RECORD AS THE DECEASED AT THE TIME OF DEATH? _____	<input type="checkbox"/> YES If "YES", then SKIP items 2,3,4,5 and SIGN at bottom of page 2. <input type="checkbox"/> NO (Go on to item 2)

2.	ENTER NUMBER OF LIVING CHILDREN OF THE DECEASED. INCLUDE ADOPTED CHILDREN AND STEPCHILDREN; INCLUDE GRANDCHILDREN AND STEP-GRANDCHILDREN IF THEIR PARENTS ARE DISABLED OR DECEASED; OR IF THEY HAVE BEEN ADOPTED BY THE SURVIVING SPOUSE OF THE DECEASED. IF NONE OF THE ABOVE, SHOW "NONE" AND GO ON TO ITEM 4. _____	<b>NUMBER</b>
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**PRINT NAME AND COMPLETE ADDRESS OF EACH CHILD**

Remarks -(If you need more space for explaining any answers to the questions, attach a separate sheet.)

NAME OF CHILD	ADDRESS OF CHILD (Include house number, street, apt. number, P.O. Box, rural route, city, state, and ZIP code)
RELATIONSHIP TO DECEASED (Grandchild, stepchild, etc.)	SOCIAL SECURITY NUMBER OF CHILD _____ - _____ - _____
NAME OF CHILD	ADDRESS OF CHILD (Include house number, street, apt. number, P.O. Box, rural route, city, state, and ZIP code)
RELATIONSHIP TO DECEASED (Grandchild, stepchild, etc.)	SOCIAL SECURITY NUMBER OF CHILD _____ - _____ - _____



## PRIVACY ACT NOTICE

See revised  
Privacy Act  
Statement

~~Section 204(d) of the Social Security Act, as amended, authorizes us to collect information you provide will enable us to account for the beneficiary's payments and ensures that the beneficiary's information meets. Your response is voluntary; however, failure to provide all or part of the requested information may prevent an accurate and timely decision on any claim filed, or could result in the loss of benefits.~~

~~We rarely use the information provided on this form for any purpose other than determining entitlement to benefit payments. However, we may disclose the information provided on this form in accordance with approved routine uses, which include but are not limited to the following:~~

- ~~1) To contractors and other Federal agencies, as necessary, for the purpose of assisting the Social Security Administration in the efficient administration of its programs;~~
- ~~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 Veteran's 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 and 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 System of Record Notice 60-0090. The notice, additional information regarding this form, and information regarding our programs and systems are available on-line at [www.socialsecurity.gov](http://www.socialsecurity.gov) or at your local Social Security office.~~

~~**Paperwork Reduction Act Statement** - This information collection is 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 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.**~~

*SSA will insert the following revised Privacy Act Statement into the form at its next scheduled reprinting:*

### **PRIVACY ACT STATEMENT**

Section 204(d) of the Social Security Act, as amended, authorizes us to collect this information. We will use this information to help us determine the beneficiary's payment.

Furnishing us the information is voluntary. However, failing to provide us with all or part of the requested information may prevent us from making an accurate and timely decision on your claim, which may result in the loss of payments.

We rarely use the information you supply for any purpose other than for determining problems in Social Security programs. 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 contractors and other Federal agencies, as necessary, for the purpose of assisting the Social Security Administration in the efficient administration of its programs;
2. To comply with Federal laws requiring the release of information from Social Security records (e.g., to the Government Accountability Office 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 and investigatory activities necessary to assure the integrity and improvement 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. 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, incorrect payments or delinquent debts under these programs.

A complete list of our routine uses for this information is available in our Privacy Act Systems of Records Notices, 60-0089, Claims Folder Systems, and 60-0090, Master Beneficiary Record. These notices, additional information regarding our programs and systems, are available online at [www.socialsecurity.gov](http://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 (OMB) control number. We estimate that it will take about 10 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.***