

**STATEMENT REGARDING DATE OF BIRTH AND CITIZENSHIP**

(Do not write in this space)

This report is authorized by section 205(a) of the Social Security Act, as amended (42 U.S.C. 405(a)). While your response is voluntary, your cooperation is needed to help us make a determination about the date of birth and/or citizenship of the person named below.

All items on this form requiring an answer must be answered or marked "Unknown."

\_\_\_\_\_ / \_\_\_\_ / \_\_\_\_\_  
 (Name of wage earner, self-employed person, or SSI applicant) (Social Security Number)

I, \_\_\_\_\_, understand that the information I give will be used with  
 (Name of person making this statement)  
 an application for benefits payable under the Social Security Act.

1. Give full name of person about whom this statement is made:	2. How many years have you known this person?
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3. When was he or she born? (Month, day, year)	4. Where was he or she born? (City or county--State or foreign country)
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5. How did you learn about this person's date of birth? (Tell fully how you know when this person was born.)

6. How are you related to this person? (If not related, write "None.")

7. When and Where Were YOU Born?	MONTH-DAY-YEAR	CITY OR COUNTY	STATE OR FOREIGN COUNTRY
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**I know that anyone who makes a false statement or representation of a material fact in an application or for use in determining a right to payment under the Social Security Act commits a crime punishable under Federal and/or State law by fine, imprisonment or both. I affirm that all information I have given in this document is true.**

**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
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**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

Sections 205(a) and 1631(e)(1)(A) and (B) of the Social Security Act, as amended, [42 U.S.C. 405(a)] and [42 U.S.C. 1383(e)(1)(A) and (B)] authorize us to collect this information. We will use the information you provide to help us establish age and or citizenship.

The information you provide on this form is voluntary. However, failure to provide 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 you provide on this form for any purpose other than for the reasons explained above. 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, including but not limited to the following:

1. To enable a third party or an agency to assist us in establishing rights 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, General Services Administration, National Archives Records Administration, 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, or investigative activities necessary to assure the integrity and improvement of our programs (e.g., to the U.S. Census Bureau 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. 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.

Additional information regarding this form, routine uses of information, and our systems and programs, is available on-line at [www.socialsecurity.gov](http://www.socialsecurity.gov) or at any Social Security office.

### Paperwork Reduction Act (PRA) 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 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 at [www.socialsecurity.gov](http://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 21235-6401. Send only comments relating to our time estimate to this address, not the completed form.**