Form Approved
OMB No. 0960-0034

SOCIAL SECURITY

Refer to:

Date:

Social Security Number:

Worker's Name:

Area Code:
Telephone:

So that we may determine the above-named person's eligibility for Social Security benefits, please furnish the amount of gross wages earned by the employee in each of the months checked below. If no wages were earned in a month, show "none."

Please note that we need to know the amounts earned for services performed within the calendar month, regardless of the amounts paid. If the employee received cash tips, include the amount in the totals for the month.

We appreciate your cooperation in furnishing this information. An envelope requiring no postage is enclosed for your convenience. A computerized printout in any format may be substituted for the enclosed form.

Sincerely yours,

Enclosure

Beginning Date of Employment: _____ Ending Date of Employment:_____

Year _____

If the amount of wages for each month is the same, enter the monthly amount here. $_____

☐ January $_____	☐ April $_____	☐ July $_____	☐ October $_____
☐ February_____	☐ May _____	☐ August _____	☐ November _____
☐ March _____	☐ June _____	☐ September_____	☐ December _____

☐ See other side for additional years *(check if applicable).*

Year _______ If the amount of wages for each month is the same, enter the monthly amount here. $ _________

☐ January $ _________	☐ April $ _________	☐ July $ _________	☐ October $ _________
☐ February _________	☐ May _________	☐ August _________	☐ November _________
☐ March _________	☐ June _________	☐ September _________	☐ December _________

Year _______ If the amount of wages for each month is the same, enter the monthly amount here. $ _________

☐ January $ _________	☐ April $ _________	☐ July $ _________	☐ October $ _________
☐ February _________	☐ May _________	☐ August _________	☐ November _________
☐ March _________	☐ June _________	☐ September _________	☐ December _________

Year _______ If the amount of wages for each month is the same, enter the monthly amount here. $ _________

☐ January $ _________	☐ April $ _________	☐ July $ _________	☐ October $ _________
☐ February _________	☐ May _________	☐ August _________	☐ November _________
☐ March _________	☐ June _________	☐ September _________	☐ December _________

Year _______ If the amount of wages for each month is the same, enter the monthly amount here. $ _________

☐ January $ _________	☐ April $ _________	☐ July $ _________	☐ October $ _________
☐ February _________	☐ May _________	☐ August _________	☐ November _________
☐ March _________	☐ June _________	☐ September _________	☐ December _________

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.

EMPLOYER		AREA CODE AND TELEPHONE NO.
NAME	TITLE	DATE

Privacy Act Statement
Collection and Use of Personal Information

Sections 1611(c), 1612(a)(1), and 1631(e)(1) of the Social Security Act, as amended, authorize us to collect the information on this form. The information you provide will help us verify wages or resolve wage discrepancies for the individual named on this form. 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 loss of benefits.

We rarely use the information you supply for any purpose other than for wages or resolving wage discrepancies. 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 60-0090, entitled Master Beneficiary Record, and 60-0103, entitled Supplemental Security Income Record. Additional information about these and other system of records notices and our programs is 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 control number. The OMB control number for this collection is 0960-0034. We estimate that it will take about 40 minutes to read the instructions, gather the facts, and answer the questions. ***Send only comments relating to our time estimate to***: *SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.*