CERTIFICATE OF ELECTION FOR REDUCED WIDOW(ER)'S AND SURVIVING DIVORCED SPOUSE'S BENEFITS

1. Print Name of Wage Earner or Self-Employed Person *(Hereafter called "Worker")*	Enter His or Her Social Security Number
2. Print Your Full Name *(First name, middle initial, last name)*	Enter Your Social Security Number *(If "none" or "unknown" so indicate.)*

INFORMATION ABOUT REDUCED WIDOW(ER)'S AND SURVIVING DIVORCED SPOUSE'S BENEFITS

The law requires that you complete and return this Certificate of Election if you wish to receive a reduced widow's, widower's or surviving divorced spouse's benefit and are at least age 62 and under full retirement age (FRA).

The following will affect the amount of your benefit:

- The month and year you elect to begin to receive benefits will determine the amount of your monthly payments which will continue at a reduced rate even after you reach FRA.
- Depending on your date of birth, the rate of reduction applied to your benefit amount can range from 19/40 to 19/56 of 1 percent times the number of months from the start of the reduced benefits until the month you reach FRA.
- If another beneficiary is entitled to a monthly survivor benefit on this Social Security number, your benefit may be reduced by the total family benefit payable in the month. The benefit paid to a surviving divorced spouse will not affect the benefit amount paid to other family members who receive benefits on the same record.

INFORMATION ON HOW BENEFITS ARE AFFECTED IF THE DECEASED WORKER RECEIVED REDUCED RETIREMENT BENEFITS

If the deceased worker received retirement benefits before FRA, the maximum survivor's benefit is limited to the higher amount that the deceased worker would have received if still alive or 82.5 percent of the deceased worker's unreduced benefit. Because of this limit, delaying receipt of reduced benefits will not necessarily increase the monthly benefit amount payable. We will review your election in item 3 below to make sure that the month selected maximizes your benefit amount.

3. I elect to accept permanently reduced benefits as provided in Section 202(q) of the Social Security Act, beginning with → Enter any month beginning with the month of the deceased worker's death up to, but not including the month you reach FRA provided that the month you choose is within the past 12 months.	MONTH	YEAR

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 *(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	Enter Name of County (if any) in which you now live

Witnesses are required ONLY if this certificate has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the person completing this certificate 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)*

(over)

Privacy Act Statement

Collection and Use of Personal Information

Sections 202(e), (f) and (q) of the Social Security Act, as amended, authorize us to collect this information. We will use the information you provide to make a determination regarding your eligibility for reduced benefits as a widow(er) or surviving divorced spouse.

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 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 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. Additional information about this and other system of records notices and our programs is available online at www.socialsecurity.gov or at your local Social Security office.

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 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. We estimate that it will take about 2 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. 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.***