

**APPLICATION FOR CHILD'S INSURANCE BENEFITS**

(Do not write in this space)

With this application, you are applying on behalf of the child or children listed in item 3 below for all insurance benefits for which they may be eligible under Title II (Federal Old-Age, Survivors and Disability Insurance) of the Social Security Act as presently amended. If you are applying on your own behalf, answer the questions on this form with respect to yourself.

If you are applying for benefits based on the earnings record of a Deceased Worker, this may also be considered an application for survivors benefits under the Railroad Retirement Act and for Veterans Administration payments under Title 38, U.S.C., Veterans Benefits, Chapter 13 (which is, as such, an application for other types of death benefits under Title 38).

Life Claim       Death Claim

1.	(a) PRINT name of Wage Earner or Self-Employed person (herein referred to as the "Worker").	FIRST NAME, MIDDLE INITIAL, LAST NAME
	(b) PRINT Worker's Social Security number.	
2.	(a) PRINT your name (unless you are the Worker).	FIRST NAME, MIDDLE INITIAL, LAST NAME
	(b) PRINT your Social Security number.	

**PART 1 - INFORMATION ABOUT THE WORKER'S CHILDREN**

3. The Worker's children (including natural children, adopted children, and stepchildren) or dependent grandchildren (including step grandchildren) may be eligible for benefits based on the earnings record of the Worker. For a living Worker, the information below applies to this month or to any of the past 12 months. For a deceased Worker, the information below applies to the date of death or for any period since the Worker's death.

<ul style="list-style-type: none"> <li>• Under age 18</li> <li>• Age 18 to 19 and attending elementary or secondary school full-time</li> <li>• Disabled or Handicapped (age 18 or over and disability began before age 22)</li> </ul>	Check (X) Sex of Child		Date of Birth (Mo., day, yr.)	Check (X) if Child 17 or Older is:		Check (X) the Column That Shows Child's Relationship to Worker						CHILD'S SOCIAL SECURITY NUMBER
	M	F		Student	Disabled	Legitimate	Adopted	Stepchild	Dependent Grandchild	Other		
FULL NAME OF CHILD	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

If you do not wish to be payee for any child or dependent grandchild named above, list the child's name and address in "Remarks" on page 5. You may apply for a child even though you do not wish to be payee for the child's benefits.

4.	If any children in item 3 are stepchildren of the Worker, enter the date the Worker married the natural parent.	MONTH, DAY, YEAR
5.	(a) Is there a legal representative (guardian, conservator, curator, etc.) for any of the children in item 3?	<input type="checkbox"/> Yes (if "Yes," complete (b) and (c).) <input type="checkbox"/> No (If "No," go on to item 6.)

(b) Write the following information about the legal representative(s):	NAME (First name, middle initial, last name)	TELEPHONE NUMBER (INCLUDE AREA CODE)
	ADDRESS	

(c) Briefly explain the circumstances which led the court to appoint a legal representative.

6. Are you the natural or adoptive parent of the person(s) for whom you are filing?  Yes  No

7. Have any children in item 3 ever been adopted by someone other than the Worker? (If "Yes," enter the following information):  Yes  No

Name of Child	Date of Adoption	Name of Person Adopting

8. Are all the children in item 3 now living in the same household with you? (If "No," enter the following information about each child not living with you. If uncertain as to the whereabouts of any of these children, explain in "Remarks".)  Yes  No

Name of Child Not Living With You	Person With Whom Child Now Lives	
	Name and Address	Relationship to Child

9. Has any child in item 3 ever been married? (If "Yes," enter the information requested below.)  Yes  No

Name of Child	Date of Marriage (Month, day, year)
How Marriage Ended (If still married, write "not ended").	Date Marriage Ended (Month, day, year)

10. Has anyone ever before filed an application with the Social Security Administration for monthly benefits on behalf of any child in item 3? (If "Yes," enter below the name(s) of the child(ren) and the name(s) and Social Security number(s) of the person(s) on whose earnings record any other claim was based.)  Yes  No

Name of Child	Name of Worker	Social Security Number of Worker

**If you are applying ONLY for a child age 18 or over who is disabled, omit items 11 through 14. In all other cases, answer items 11 through 14.**

**EARNINGS INFORMATION FOR LAST YEAR (Do not complete if the Worker died this year)**

11. (a) Did any child in item 3 earn more than the exempt amount last year? <i>(If "Yes," answer (b). If "No," go on to item 12.)</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
(b) NAME OF CHILD WHO EARNED OVER THE EXEMPT AMOUNT LAST YEAR	TOTAL EARNINGS OF CHILD	LIST EACH MONTH THAT CHILD DID NOT EARN MORE THAN \$ _____ IN WAGES AND DID NOT PERFORM SUBSTANTIAL SERVICES IN SELF-EMPLOYMENT
	\$	
	\$	
	\$	

**EARNINGS INFORMATION FOR THIS YEAR**

12. (a) Do you expect the total earnings of any child in item 3 to be more than the exempt amount this year? (Count all earnings beginning with the first of this year and all anticipated earnings through the end of this year.) (If "Yes," answer (b). If "No," go on to item 13.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
(b) NAME OF CHILD WHO EXPECTS TO EARN OVER THE EXEMPT AMOUNT THIS YEAR	EXPECTED EARNINGS OF CHILD	LIST EACH MONTH (INCLUDING THE PRESENT MONTH) THAT CHILD DID NOT OR WILL NOT EARN MORE THAN \$ _____ IN WAGES AND DID NOT OR WILL NOT PERFORM SUBSTANTIAL SERVICES IN SELF-EMPLOYMENT
	\$	
	\$	
	\$	

**Complete item 13 ONLY if any child is now in the last 4 months of the child's taxable year (Sept., Oct., Nov., and Dec., if the taxable year is a calendar year).**

**EARNINGS INFORMATION FOR NEXT YEAR**

13. (a) Do you expect the total earnings of any child in item 3 to be more than the exempt amount next year? (If "Yes," answer (b). If "No," go on to item 14.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
(b) NAME OF CHILD WHO EXPECTS TO EARN OVER THE EXEMPT AMOUNT NEXT YEAR	EXPECTED EARNINGS OF CHILD	LIST EACH MONTH THAT CHILD WILL NOT EARN MORE THAN \$ _____ IN WAGES AND WILL NOT PERFORM SUBSTANTIAL SERVICES IN SELF-EMPLOYMENT
	\$	
	\$	
	\$	

14. If any of the children for whom you are filing uses a fiscal year (one that does not end on December 31), print here the name of the child and the month the fiscal year ends.	Name of child and month fiscal year ends
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**Complete items 15 and 16 ONLY if the Worker is living. Otherwise, go on to item 17.**

15. If any children in item 3 are children adopted by the Worker, print below the name of each such child and the date of adoption by the Worker.	
NAME OF ADOPTED CHILD	DATE OF ADOPTION

16.	Have all of the children in item 3 lived with the Worker during each of the last 13 months (counting the present month)? (If "No," enter the information requested below.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	NAME OF CHILD WHO DID NOT LIVE WITH THE WORKER IN EACH OF THE LAST 13 MONTHS	LIST EACH MONTH IN WHICH THIS CHILD DID NOT LIVE WITH THE WORKER	PERSON WITH WHOM CHILD LIVED NAME AND ADDRESS
			RELATIONSHIP TO CHILD
17.	If any of the children in item 3 are within 2 months of age 65 or older, blind or disabled, do you want to file on his/her behalf for Supplemental Security Income?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**PART II - INFORMATION ABOUT THE DECEASED.** Complete items 18 through 26 only if the Worker is deceased.

18.	(a) Print date of birth of Worker	MONTH, DAY, YEAR	
	(b) Print Worker's name at birth if different from item 1 (a)		
	(c) Check (X) one for the Worker	<input type="checkbox"/> Male	<input type="checkbox"/> Female
19.	(a) Print date of death	MONTH, DAY, YEAR	
	(b) Print place of death	CITY AND STATE	
20.	Print the name of the state or foreign country where the Worker had a fixed, permanent home at the time of death.	STATE OR FOREIGN COUNTRY	
21.	Did the Worker work in the railroad industry for 5 years or more?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
22.	(a) Was the Worker in the active military or naval service (including Reserve or National Guard active duty or active duty for training) after September 7, 1939 and before 1968?	<input type="checkbox"/> Yes (If "Yes," answer (b) and (c).)	<input type="checkbox"/> No (If "No," go on to item 23.)
	(b) Enter dates of service	FROM (month-year)	TO (month-year)
	(c) Has anyone (including the Worker) received, or does anyone expect to receive, a benefit from any other Federal agency?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
23.	(a) Did the worker have social security credits (for example, based on work or residence) under another country's social security system?	<input type="checkbox"/> Yes (If "Yes," answer (b).)	<input type="checkbox"/> No (If "No," go on to item 24.)
	(b) List the country(ies).		
24.	(a) Did the worker have wages or self-employment income covered under Social Security in all years from 1978 through last year?	<input type="checkbox"/> Yes (If "Yes," skip to item 25.)	<input type="checkbox"/> No (If "No," answer (b).)
	(b) List the years from 1978 through last year in which the worker did not have wages or self-employment income covered under Social Security.		

Answer item 25 ONLY if death occurred within the last 2 years.

25.	(a) About how much did the Worker earn from employment and self-employment during the year of death?	AMOUNT \$
	(b) About how much did the Worker earn the year before death?	AMOUNT \$

26. Check if applicable:  
 I am not submitting evidence of the deceased's earnings that are not yet on his/her earnings record. I understand that these earnings will be included automatically within 24 months, and any increase in my benefits will be paid with full retroactivity.

27. (a) Did the Worker ever file an application for Social Security benefits, a period of disability under Social Security, Supplemental Security Income, or hospital or medical insurance under Medicare?  Yes  No  Unknown  
 (If "Yes," answer (b) and (c).) (If "No" or "Unknown," go on to item 28.)

(b) Enter name of person(s) on whose Social Security record other application was filed.

(c) Enter Social Security number of person named in (b).  
 (If "Unknown," so indicate.)

**Answer item 28 ONLY if the Worker died prior to age 66 and within the past 4 months.**

28. (a) Was the Worker unable to work because of a disabling condition at the time of death?  Yes  No  
 (If "Yes," answer (b).)

(b) Enter date disability began MONTH, DAY, YEAR

29. Were all the children in item 3 living with the Worker at the time of death?  Yes  No  
 (If "No," enter the following information)

NAME OF CHILD NOT LIVING WITH THE WORKER	PERSON WITH WHOM CHILD WAS LIVING	
	NAME AND ADDRESS	RELATIONSHIP TO CHILD

REMARKS: (You may use this space for any explanations. If you need more space, attach a separate sheet.)

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. 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.

SIGNATURE OF APPLICANT	Date (Month, day, year)
SIGNATURE (First Name, Middle Initial, Last Name) (Write in ink)	Telephone Number(s) at Which You May be Contacted During the Day (Include Area Code)

**Direct Deposit Payment Information (Financial Institution)**

Routing Transit Number	Account Number	<input type="checkbox"/> Checking	<input type="checkbox"/> Enroll in Direct Express
		<input type="checkbox"/> Savings	<input type="checkbox"/> Direct Deposit Refused

Applicant's Mailing Address (Number and street, Apt No., P.O. Box, or Rural Route) (Enter Residence Address in "Remarks," if different.)

City and State	ZIP Code	County (if any) in which you now live
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Witnesses are required ONLY if this application has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the applicant must sign below giving their full addresses. Also, print the applicant's name in the signature block.

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 202, 205, and 223 of the Social Security Act, as amended, authorize us to collect this information. We will use the information you provide to determine eligibility for monthly benefits or insurance coverage.

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, or could result in the loss of benefits.

We rarely use the information you supply us for any purpose other than to make a determination regarding eligibility for monthly benefits and authorize payments to the child or children of living or deceased workers. However, we may use it for the administration and integrity of our programs. We may also disclose the 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 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 and 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 Bureau of the Census and to private entities under contract with us).

We also may use the information you give us in computer matching programs. Matching programs compare our records with records kept by other Federal, State and 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.

A complete list of routine uses of the information you provided us is available in our Systems of Records Notices entitled, Claims Folder System, 60-0089 and Medicare Database (MDB) File, 60-0321. Additional information about these and other system of records notices and our programs are available online at [www.socialsecurity.gov](http://www.socialsecurity.gov) or at your local Social Security office.

**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 12 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.

**RECEIPT FOR YOUR CLAIM FOR SOCIAL SECURITY CHILD'S INSURANCE BENEFITS**

TELEPHONE NUMBER(S) TO CALL IF YOU HAVE A QUESTION OR SOMETHING TO REPORT	<b>BEFORE YOU RECEIVE A NOTICE OF AWARD</b>	SSA OFFICE	DATE CLAIM RECEIVED
	<b>AFTER YOU RECEIVE A NOTICE OF AWARD</b>		

Your application for Social Security benefits on behalf of the child(ren) named below has been received. You will be notified by mail as soon as a decision is made on your claim.

You should hear from us within \_\_\_\_\_ days after you have given us all the information we requested. Some claims may take longer if additional information is needed.

In the meantime, if you or any child(ren) changes address, or if there is some other change that may affect your claim, you or someone for you should report the change. The changes to be reported are listed below.

Always give us your claim number when writing or telephoning about your claim.

If you have any questions about your claim, we will be glad to help you.

CLAIMANT	SOCIAL SECURITY CLAIM NUMBER

WORKER'S NAME *(If surname differs from name of claimant(s).)*



## CHANGES TO BE REPORTED AND HOW TO REPORT

### FAILURE TO REPORT MAY RESULT IN OVERPAYMENTS THAT MUST BE REPAYED AND IN POSSIBLE MONETARY PENALTIES

- You or any child changes mailing address for checks or residence. (To avoid delay in receipt of checks you should ALSO file a regular change of address notice with your post office.)
- Any child's citizenship or immigration status changes.
- Any beneficiary goes outside the U.S.A. for 30 consecutive days or longer.
- Any beneficiary dies or becomes unable to handle benefits.
- Work changes - On your application you told us \_\_\_\_\_ expected total earnings for \_\_\_\_\_ (Name of Child) \_\_\_\_\_ to be \$ \_\_\_\_\_  
\_\_\_\_\_  (is)  (is not) earning wages of \_\_\_\_\_ (Name of Child) more than \$ \_\_\_\_\_ a month.  
\_\_\_\_\_  (is)  (is not) self-employed (Name of Child) and rendering substantial services in a trade or business. (Report AT ONCE if this work pattern changes.)
- Custody Change - Report if a child for whom you are filing or who is in your care dies, leaves your care or custody, or changes address.
- The child age 13 or older has an unsatisfied warrant for more than 30 days for his or her arrest, or a crime or attempted crime that is a felony of flight to avoid prosecution or confinement, escape from custody and flight-escape. In most jurisdictions that do not classify crimes as felonies, a crime that is punishable by death or imprisonment for a term exceeding one year.
- The child age 13 or older has for more than 30 continuous days committed a violation of probation or parole under Federal or State law.
- A student, age 18 or over, stops attending school, reduces school attendance below full-time, changes schools, or is paid by an employer to attend school.
- If the worker and stepchild's parent divorce. Benefits are not payable to a stepchild beginning with the month after the month the worker and the stepchild's parent divorce. Promptly return any benefit payment received on behalf of the stepchild for the months after the month the divorce becomes final.
- The child is confined for more than 30 continuous days to a jail, prison, penal institution or correctional facility for conviction of a crime or confined to a public institution by a court order in connection with a crime.
- Change in Marital Status - Marriage, divorce, or annulment of marriage. You must report marriage even if you believe that an exception applies.
- Disability Applicants - In addition to the applicable reporting requirements listed above:
  1. The disabled adult child returns to work (as an employee or self-employed) regardless of amount of earnings.
  2. The disabled adult child's condition improves.

An agency in your State that works with us in administering the Social Security disability program is responsible for making the disability decision on the child's claim. In some cases, it is necessary for them to get additional information about the child's condition or to arrange for the child to have a medical examination at Government expense.

### HOW TO REPORT

You can make your reports by telephone, mail, or in person, whichever you prefer.

If you are awarded benefits and one or more of the above change(s) occur, you should report by:

- Visiting the section "What You Can Do Online" at our web site at [www.socialsecurity.gov](http://www.socialsecurity.gov);
- Calling us TOLL FREE at 1-800-772-1213;
- If you are deaf or hearing impaired, calling us TOLL FREE at TTY 1-800-325-0778; or
- Calling, visiting or writing your local Social Security office at the phone number and address above.

For general information about Social Security, visit our web site at [www.socialsecurity.gov](http://www.socialsecurity.gov).

For those under full retirement age, the law requires that a report of earnings be filed with SSA within 3 months and 15 days after the end of any taxable year in which the child earns more than the annual exempt amount. You may contact SSA to file a report for the child. Otherwise, SSA will use the earnings reported by the child's employer(s) and the child's self-employment tax return (if applicable) as the report of earnings required by law, to adjust benefits under the earnings test. It is your responsibility to ensure that the information you give concerning the child's earnings is correct.