



If you want to get in touch with the person who started your Internet application, the address is: [REDACTED]. The telephone number is \_\_\_\_\_.

AFB042  
Address  
changed to  
uppercase

**If You Have Any Questions** [REFC01]

If you have any questions, call, write, or visit any Social Security office and have this letter with you. The telephone number and mailing address of your local office are shown at the top of this letter. [REF116]

You can also reach us at 1-800-772-1213 (TTY 1-800-325-0778). We can answer most questions over the phone. The office is located at:

\_\_\_\_\_(10b)\_\_\_\_ [AFBH01]  
\_\_\_\_\_(10c)\_\_\_\_  
\_\_\_\_(10d)\_\_\_\_(10e)\_\_\_\_(10f)\_\_\_\_

{Insert choice of UTI SSAS30 - SSAS39 (Signature Authority: Regional Commissioner's printed name and designation) based on applicant's zip code.}

Enclosure(s):  
Pub 05-11069

ENC008  
New enclosure  
for Notice1

# Social Security Administration Retirement, Survivors and Disability Insurance

Important Information

SSAH05

\_\_\_\_ (1b) \_\_\_\_\_  
\_\_\_\_ (1c) \_\_\_\_\_  
\_\_\_\_ (1d) \_\_\_\_\_ (1e) \_\_\_\_\_ (1f) \_\_\_\_\_

MESH08

Date: \_\_\_\_\_ (2) \_\_\_\_\_  
Claim Number: \_\_\_\_\_ (13) \_\_\_\_\_

SSAH28

\_\_\_\_ (4a) \_\_\_\_\_  
\_\_\_\_ (4b) \_\_\_\_\_  
\_\_\_\_ (4c) \_\_\_\_\_  
\_\_\_\_ (4d) \_\_\_\_\_ (4e) \_\_\_\_\_ (4f) \_\_\_\_\_

SSAH32

Phone Number: \_\_\_\_\_ (1h) \_\_\_\_\_  
Confirmation Number: \_\_\_\_\_ (3) \_\_\_\_\_

SSAH93

HDR020

An Internet application for **Social Security benefits/Medicare insurance** was **started/completed** for you by \_\_\_\_\_ on \_\_\_\_\_.

AFB032  
New  
fill-in

If you do not want these benefits, you do not need to contact us. We will not take any action unless we receive your **signed** application.

AFB038

## What You Need to Do

RCOC02

- Review all the entries on the application and confirm that the information is correct.
- Correct any information that is wrong and write your initials next to it.
- Sign and date the application in the space shown as, "Your Signature."

AFB047

**NOTE:** It is important that **you** sign the application, not the person who filled it in for you or anyone else.

- Gather the documents shown on the enclosed **List of Acceptable Evidence Documents**. **We will return all documents and photocopies to you unless you tell us you don't want them.**
- If you decide to continue applying for disability, complete **the form** SSA-827 (Authorization to Disclose Information to the Social Security Administration) as shown below:
  1. Read the entire form SSA-827, front and back.
  2. Write your name and Social Security Number in the upper right corner of **the** form.

AFB048

AFB049  
Text  
changes  
;  
RIB/DIB  
only

3. Sign **the** form in the space shown as “INDIVIDUAL authorizing disclosure.”

4. Enter your address and daytime phone number in the spaces shown for them.

5. Date **the** form in the space shown as “Date Signed.”

AFB049

6. Do not fill in the large empty box in the middle of the form, put a check in the empty block under “PURPOSE,” or complete any other sections of the form.

7. Have a witness sign and provide his or her address or phone number in the space shown on **the** form. If you sign with an “X,” have a second witness sign and provide his or her address.

- Mail or bring the signed application, any proofs requested on the **List of Acceptable Evidence (C1)** and **the signed** Medical Release **form** (SSA-827). **(C2)** If you mail them, please follow the mailing instructions on the final page of this notice and add your return address and correct postage to the envelope provided. If the office location is different than the mailing address, it is listed in “If You Have Any Questions.”

AFB050  
Text  
changes

- If you do not want to apply for disability, you do not need to return the SSA-827 with your retirement application.

AFB051 text  
change; RIB/DIB only

### What Happens Next CAP005

Once we receive your signed application, we will decide if you can get benefits. The sooner we receive it, the sooner we can decide.

AFB052

We may use \_\_\_\_\_ as the official date of this application. In order to use \_\_\_\_\_, we must receive the **signed** application by \_\_\_\_\_. You may **lose Social Security benefits** if we do not receive the signed application by \_\_\_\_\_.

Supplemental Security Income or SSI is a federal program that provides monthly payments to people who have limited income and assets and who are age 65 or older, or blind, or have a disability. For more information about the SSI program, please read the pamphlet, Supplemental Security Income.

AFB066

If you intend to file for SSI, you need to file your application with us by \_\_\_\_\_ or you may lose SSI benefits. Call us at 1-800-772-1213 (TTY 1-800-325-0778) to arrange an appointment to file for SSI. You cannot apply for SSI over the Internet.

AFB065  
Text and  
fill-in  
changes

### Confirmation Number CAP006

You can check the status of your application on the Internet. Please wait at least 5 business days from the date you mail or bring your signed application to us before you check your application status. **Just go to the “Social Security Online” home page at [www.socialsecurity.gov](http://www.socialsecurity.gov), select “Check the Status of Your Application”, then enter the Confirmation**

AFB053  
Text  
and  
fill-in  
change

Number shown at the top of this notice. Please guard this number carefully. It's the key to your application information. Social Security employees will never ask for your Confirmation Number.

Disability claims take longer to process than other types of Social Security claims because of the need to obtain sufficient medical evidence to show that you are disabled. It may take 90-120 days before "Check the Status of Your Application" will reflect a final decision on your disability claim.

AFB054  
Text  
change

**Reporting Responsibilities**

BRRC01 new UTI

It is important that you let us know as soon as possible whenever one of the changes listed below occurs. You need to contact us if:

AFB078  
New  
UTI

- you change your mailing address;
- your citizenship or immigration status changes; or
- your Medicare Part B premium is automatically paid from an account at a bank or other financial institution, and you change institutions or close the account.

You can call, write, visit our office or our website at <http://www.socialsecurity.gov/pgm/reach.htm> to make a report. You should have your Social Security number handy when you contact us.

Information you give to another government agency may be provided to Social Security by the other agency, but you must also report any changes to us.

**Additional Information** CAP003

If you want to get in touch with the person who completed your application, the address is: \_\_\_\_\_ . The telephone number is \_\_\_\_\_.

AFB042  
Address in  
uppercase

**If You Have Any Questions** REFC01

If you have any questions, call, write, or visit any Social Security office and have this letter with you. The telephone number and **mailing** address of the office processing your claim are shown at the top of this letter. You can also reach us at 1-800-772-1213 (TTY 1-800-325-0778). We can answer most questions over the phone. The office location is: **(C3)**

REF116

\_\_\_\_\_(10b)\_\_\_\_\_  
\_\_\_\_\_(10c)\_\_\_\_\_  
\_\_\_\_\_(10d)\_\_\_\_\_(10e)\_\_\_\_\_(10f)\_\_\_\_\_  
AFBH01

{Insert choice of UTI SSAS30 - SSAS39 (Signature Authority:

Regional Commissioner's printed name and designation) based on applicant's zip code.}

Enclosure(s):  
Return Envelope  
Application Summary  
Pub 05-11069  
List of Acceptable Evidence Documents  
Medical Release (SSA-827)

ENC008  
Two new  
enclosures

AFB055

### List of Acceptable Evidence Documents

You need to send us the documents shown below. **Send all documents you have with your signed application.** We will help you get the other documents. **You should not delay sending your application if you don't have all the documents.** You may lose benefits if you delay.

**NOTE:** Include your Social Security number when you mail documents to us. We need this to match the documents to your application. Please write your Social Security number on a separate sheet of paper and include it in the envelope with your documents. Do not write anything on your original documents. You may bring the documents to any Social Security office if you don't want to mail them. They will be examined and returned to you.

**CAUTION: Don't** mail foreign birth records or any Department of Homeland Security (DHS) documents to us – especially those you are required to keep with you at all times. These documents are extremely difficult, time-consuming, and expensive to replace if lost. Some cannot be replaced. Instead, bring them to any Social Security office where they will be examined and returned to you.

#### Proof of Age CAP007

You **must submit** a birth certificate or religious record of birth made before you were age 5 **if one was established.** This is our preferred proof of age.

AGE012

You need to provide at least two other documents to prove your age if a public or religious record was not made prior to age 5. Examples of other documents include a delayed birth certificate, school records, a State census record, vaccination record, insurance policy, hospital admission record, etc. Please provide us with two of the oldest of these documents.

**We must see the original document(s).** We **cannot** accept photocopies unless they are certified by the office that issued the original. We will return any document you show us.

## Proof of Citizenship or Naturalization CAP008

We can accept most documents that show that you were born in the United States. We need to see a document such as a U.S. consular report of birth, a U.S. passport, a Certificate of Naturalization, or a Certificate of Citizenship if you are a U.S. citizen born outside the U.S. We need to see your INS Form 1-551 (Green Card) to verify your 9-digit Alien Registration Number (A-Number) if you are not a U.S. citizen. We need to see your INS Form I-94 to verify your Admission Number if you have an 11-digit Admission Number, even if you have an A-Number.

CZN067

**We must see the original documents**, but we **cannot** accept them if they have expired. We cannot accept photocopies.

## Proof of U.S. Military Service Before 1968

MSV007

Your benefit amount may increase if you have any period of active duty in the U.S. military prior to 1968. We need proof of your active duty service to determine this. Military service credits for active duty are automatically posted after 1967. Proof of U.S. military service includes your military service papers (e.g., Form DD-214-Certification of Release or Discharge from Active Duty). We need to see all DD-214s with beginning and ending dates of active duty prior to 1968. We can accept uncertified photocopies of your military service.

MSV007

## Proof of Wages from Your Employer

WAG031

We need to see Form W-2 for wages you received last year. We can accept pay stubs or statements for the current year as long as Social Security earnings (also known as FICA or OASDI earnings) are displayed separately. We can accept uncertified photocopies of your W-2 forms.

## Proof of Self-Employment Income

SEI004  
MER013

We need to see a copy of Schedule C and SE from your tax return for last year. We can accept uncertified photocopies of your self-employment tax returns.

## Medical Evidence

We will ask for your medical documents if you have received treatment for your alleged disability. This includes copies or photocopies of medical records, doctors' reports, and recent test results. Your treatment records are used along with other information to see if you meet our definition of disability.

We need information about your medical treatment for any illnesses, injuries, or conditions that limit your ability to work. We will not need to request copies of medical documents from your doctors, hospitals, clinics, or other medical sources if you already have them. We can process your application faster with this information. **Do not delay filing your application if you do not have these documents.** We will ask the medical sources you list to send them to us. We may ask you to go to a special examination at our expense if you have not received treatment, or we do not obtain enough documents about your condition(s).

We also ask for information such as:

- What are your illnesses, injuries, or conditions?
- When did they begin?
- How do they limit your activities?
- What did medical test show?
- What treatment did you receive?

In addition, we ask for information about your ability to do work-related activities, such as walking, sitting, lifting, carrying, and understanding and remembering instructions.

We do **not** ask your doctors to decide if you are disabled.

We can accept uncertified photocopies of your medical documents.

### **Proof of Workers' Compensation and/or Similar Benefits**

WCP056

You indicated that you received or are receiving a temporary or permanent workers' compensation-type benefit. We need to see award letters, pay stubs, settlement agreements or other proof you may have.

We will need documents that show:

- The date of your injury or illness;
- The amount and effective date of your current payment and all increases or decreases within the last 17 months or, if later, since payments began;
- The type of payment if you receive workers' compensation (i.e., temporary partial, temporary total, permanent partial, permanent total, a lump sum, or an annuity);
- The frequency of your payments (e.g., weekly, bi-weekly, monthly, bi-monthly, etc.) or the period covered by a lump sum;
- The last day you were entitled to a payment and the last payment amount (if different from your regular payment amount) if benefits have already ended;
- The name, address, and phone number of your employer;
- The name, address, and phone number of the insurance carrier if they make the payments instead of your employer.

WCP056

We can accept uncertified photocopies of your workers' compensation and/or similar benefit information.



# Internet Application Summary

AFB056  
New  
fill-in

## Instructions

This form summarizes all the information provided by the person who started an Internet application for **Social Security benefits/Medicare insurance** on your behalf.

1. Review all the entries and confirm that the information is correct.
2. Write your initials next to any corrections that you make.
3. Sign and date the application in the space shown as, "Your Signature."

**NOTE:** It is important that **you** sign the application, not the person who filled it in for you or anyone else.

4. Mail or bring the signed application to the office address shown on the notice mailed with this summary. If you mail it, add your return address and the correct postage to the envelope provided.
5. **If** the office location is different than the mailing address, it is listed under "**If You Have Any Questions**" at the end of the notice.

AFB057  
numbering  
format change  
Text

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I apply for all insurance benefits for which I am eligible under Title II (Federal Old-Age, Survivors, and Disability Insurance) and Part A **and Part B** of Title XVIII (Health Insurance for the Aged and Disabled) of the Social Security Act, as presently amended.

AFB058  
New fill-in

## (Summary below applies to RIB/DIB application only)

### Preparer's Information

Preparer's name: Doug Binder  
Preparer's organization: Binder & Binder, LLC  
Preparer's relationship to applicant: Attorney  
Preparer's address: 123 Old Court Rd., Baltimore, MD 21208  
Preparer's phone number: (410) 224-9444

### Applicant Identification

Applicant name: Erika Davies  
Social Security Number: XXX-XX-9999  
Gender: Female  
Date of Birth: October 18, 1950

### Contact Information

#### Mailing Address

Mailing Address: 3601 Clark's Lane, Baltimore, MD 21215  
Reside at this address: No  
Residence Address: 2415 St. Paul Street, Baltimore, MD 21218

### Phone and email

Daytime telephone number: 443-765-4008  
Type of phone: Other  
Best time to call: 2  
Email address: erika.seth@gmail.com

Preferred language for speaking: English  
Preferred language for reading: English

### Birth and Citizenship Information

Born in the United States or a U.S. territory or commonwealth: Yes

City of birth: Baltimore

State of birth: MD

U.S. citizen: Yes

Type of citizenship: U.S. Citizen born inside the U.S.

### Confirmation Number

The confirmation number is: 12345678

### Other Social Security Numbers

Any other Social Security Numbers used: Yes

Other SSN 1: 444-99-4444

Other SSN 2:

Other SSN 3:

Other SSN 4:

Other SSN 5:

### Other Names

Any other names used: Yes

Other name 1: Erika Seth

Other name 2:

Other name 3:

Other name 4:

Other name 5:

### Marriage Information

Currently married: Yes

Spouse's Name: Edward Davies

Spouse's Social Security Number: 909-99-9999

Spouse's age: 62

Marriage Date: April 19, 1988

Marriage Type: Married by Clergy or Public Official

Married in U.S. or a U.S. territory or commonwealth: Yes

City, town or county:

U.S. state, territory or commonwealth:

### **Prior Marriages**

First prior spouse's name: Eric Smith

First prior spouse's Social Security Number: UNKNOWN

First prior spouse's date of birth: December 15, 1952

First prior marriage began on: April 28, 1971

First prior marriage type: Clergy or Public Official

First prior marriage began in: Bath, England

First prior marriage ended on: October 4, 1974

First prior marriage ended in: Bath England

First prior marriage ended because of: Death

Second prior spouse's name: John Doe

Second prior spouse's Social Security Number: UNKNOWN

Second prior spouse's date of birth: December 15, 1952

Second prior marriage began on: April 28, 1971

Second prior marriage type: Clergy or Public Official

Second prior marriage began in: Bath, England

Second prior marriage ended on: October 4, 1974

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Second prior marriage ended in: Bath England  
Second prior marriage ended because of: Death

Third prior spouse's name: Peter Piper  
Third prior spouse's Social Security Number: UNKNOWN  
Third prior spouse's date of birth: December 15, 1952  
Third prior marriage began on: April 28, 1971  
Third prior marriage type: Clergy or Public Official  
Third prior marriage began in: Bath, England  
Third prior marriage ended on: October 4, 1974  
Third prior marriage ended in: Bath England  
Third prior marriage ended because of: Death

Fourth prior spouse's name: Grant Tomb  
Fourth prior spouse's Social Security Number: UNKNOWN  
Fourth prior spouse's date of birth: December 15, 1952  
Fourth prior marriage began on: April 28, 1971  
Fourth prior marriage type: Clergy or Public Official  
Fourth prior marriage began in: Bath, England  
Fourth prior marriage ended on: October 4, 1974  
Fourth prior marriage ended in: Bath England  
Fourth prior marriage ended because of: Death

I have NO additional prior marriages.

#### Children

Child 1: Ethan Davies  
Child 2: Ephraim Davies  
Child 3:  
Child 4:  
Child 5:  
Child 6:  
Child 7:  
Child 8:  
Child 9:  
Child 10:

I have NO additional children.

#### Military Details

Military Service prior to 1968: Yes  
Receiving or eligible to receive military or civilian Federal agency benefit: Yes  
Type of benefit: Military

First Military Period Type of Duty: Reserve  
First Military Period Branch of Service: Army  
First Military Period Start Date: 02/02/1934  
First Military Period End Date: 02/02/1936

Second Military Period Type of Duty: Reserve  
Second Military Period Branch of Service: Army  
Second Military Period Start Date: 02/02/1934  
Second Military Period End Date: 02/02/1936

Third Military Period Type of Duty: Reserve

Third Military Period Branch of Service: Army  
Third Military Period Start Date: 02/02/1934  
Third Military Period End Date: 02/02/1936

Fourth Military Period Type of Duty: Reserve  
Fourth Military Period Branch of Service: Army  
Fourth Military Period Start Date: 02/02/1934  
Fourth Military Period End Date: 02/02/1936

Fifth Military Period Type of Duty: Reserve  
Fifth Military Period Branch of Service: Army  
Fifth Military Period Start Date: 02/02/1934  
Fifth Military Period End Date: 02/02/1936

Sixth Military Period Type of Duty: Reserve  
Sixth Military Period Branch of Service: Army  
Sixth Military Period Start Date: 02/02/1934  
Sixth Military Period End Date: 02/02/1936

Seventh Military Period Type of Duty: Reserve  
Seventh Military Period Branch of Service: Army  
Seventh Military Period Start Date: 02/02/1934  
Seventh Military Period End Date: 02/02/1936

Eighth Military Period Type of Duty: Reserve  
Eighth Military Period Branch of Service: Army  
Eighth Military Period Start Date: 02/02/1934  
Eighth Military Period End Date: 02/02/1936

Ninth Military Period Type of Duty: Reserve  
Ninth Military Period Branch of Service: Army  
Ninth Military Period Start Date: 02/02/1934  
Ninth Military Period End Date: 02/02/1936

Tenth Military Period Type of Duty: Reserve  
Tenth Military Period Branch of Service: Army  
Tenth Military Period Start Date: 02/02/1934  
Tenth Military Period End Date: 02/02/1936

I have NO additional Periods of Military Duty.

#### Employer Details

Worked for an employer in 2007: YES  
Worked or will work for an employer in 2008  
Will work for an employer in 2009: YES

Employer's name: Southwest Airlines  
Employer's address: 1 Plain Dr., Chicago, IL 00747  
Date employment began: September 1987  
Date employment end: March 2007  
Another employer in 2007, 2008, or 2009: YES

Employer's name: Southwest Airlines  
Employer's address: 1 Plain Dr., Chicago, IL 00747

Date employment began: September 1987  
Date employment end: March 2007  
Another employer in 2007, 2008, or 2009: YES

Employer's name: Southwest Airlines  
Employer's address: 1 Plain Dr., Chicago, IL 00747  
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Another employer in 2007, 2008, or 2009: YES

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Another employer in 2007, 2008, or 2009: YES

Employer's name: Southwest Airlines  
Employer's address: 1 Plain Dr., Chicago, IL 00747  
Date employment began: September 1987  
Date employment end: March 2007  
Another employer in 2007, 2008, or 2009: YES

Employer's name: Southwest Airlines  
Employer's address: 1 Plain Dr., Chicago, IL 00747  
Date employment began: September 1987  
Date employment end: March 2007  
Another employer in 2007, 2008, or 2009: YES

Self-employment Details  
Self-employed in 2007: YES  
Type of business: Law firm  
Self-Employment net income greater than \$400: YES

Self-employed in 2008: YES  
Type of business: Home medical practice  
Self-Employment net income greater than \$400: YES

Self-employed in 2009: YES  
Type of business: Car wash  
Self-Employment net income greater than \$400: YES

Supplemental Information  
Worked outside the US: YES  
Eligible for benefits under a foreign social security system: YES  
Country: Pakistan

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Filed or intend to file under that country's social security system: YES  
Spouse worked outside the US: YES  
Spouse eligible for benefits under a foreign social security system: YES  
Spouse filed or intends to file under that country's social security system: YES  
Agree with the earning history as shown on Social Security statement: YES  
Corporate Officer of employer: YES  
Related to a Corporate Officer of employer: YES  
Receiving earnings from a Family Corporate or other closely held corporation: YES  
Permission granted to contact employer(s) if necessary: YES

#### Total Earnings

Total of all wages and tips in 2007: \$12000  
Earned wages, tips, and net earnings from self-employment over \$1080 a month or performed substantial services in self-employment in all months of 2007: NO  
Months did not earn over \$1080: January, March and June  
Total of all wages and tips in 2008: \$15000  
Earned wages, tips, and net earning from self-employment over \$1130 a month or performed substantial services in self-employment in all months of 2008: NO  
Months did not earn over \$1130: January and June  
Total of all wages and tips expected in 2009: \$22000  
Expected wages, tips, and net earnings from self-employment over \$1130 a month or from performing substantial services in self-employment in all months of 2009: NO  
Months will not earn over \$1130: January, March and June

Total earnings include any special payments paid in one year but earned in another: NO

#### Other Pensions/Annuities

Ever worked in a job where Social Security taxes were not deducted or withheld: YES  
Receiving a pension or annuity based on this non-covered work: YES  
Pension or annuity based on government employment: YES  
Worked on railroad 5 years or more: YES  
Receiving or eligible to receive a railroad pension or annuity: YES  
Spouse worked for railroad 5 years or more: YES  
Spouse receiving eligible to receive railroad pension or annuity: YES  
Worked for federal government in 1983: YES  
Spouse worked for Federal Government in 1983: YES

#### Direct Deposit Details

Bank routing number: 001520633  
Account number: 009979955285  
Account type: Checking  
No account: No

#### Benefit Information

Filed for Supplemental Security Income: NO  
Intend to file for Supplemental Security Income: YES  
Previous application for Medicare, Social Security Benefits, or Supplemental Security Income (SSI) benefits: YES  
Types of Benefits: Medicare, Social Security, Supplemental Security Income  
Previous filing on your own Social Security Number: NO  
Name and Social Security Number of person(s) on whose record previously applied:  
89143601

Joe Public 999-99-9999

Bill D. Blocks 990-90-9099

Enrolled in Medicare Part B: NO

Want to enroll in Medicare Part B: NO

Enrolled on own SSN: NO

Receiving Medicaid: NO

Covered under a group health plan: NO

#### Ability to Work

Limiting illnesses, injuries, or conditions: BROKEN BACK, HIGH BLOOD PRESSURE

Blind: NO

Work-related illnesses, injuries, or conditions: YES

Now able to work: YES

Date became able to work: 09/ 2000

#### Disability Payments

Filed or intend to file for workers' compensation or other public disability benefits: NO

Reason for not filing: I RECEIVE ENOUGH ALREADY –

Received money from your employer on or after date became unable to work: YES

Amount of pay received: 11234.50

Type of pay received: SICK, VACATION, OTHER

Expect to receive future payment from employer: YES

Amount of future payment from employer: 13345.90

Type of future payment from employer: SICK, VACATION, OTHER

#### Dependents

Has parent who receives one-half support from you: YES

First Parent's Name: John Doe Public

First Parent's Address: 123 Main Street, Gwynn Oak, MD 21207

Second Parent's Name: Roberta Lee Public

Second Parent's Address: 321 South Main Street, Liberty, MD 21044

Number of years without earnings while caring for child under age 3: 6

Years with no earnings: 1998, 1999, 2000, 2001, 2002, 2003, 2004

#### Authorization

Authorized disclosure of medical information: YES

Receive reduced retirement benefits while waiting for disability decision: YES

**(Summary below applies to Medicare only)**

Preparer's Information

Preparer's name: Doug Bender  
Preparer's organization: Bender & Bender, LLC  
Preparer's relationship to applicant: Attorney  
Preparer's address: 123 Old Court Rd., Baltimore, MD 21208  
Preparer's phone number: (410) 224-9444

Applicant Identification Page

Applicant Name: John Q. Smith  
Social Security Number: XXX-XX-XXXX  
Gender: Male  
Date of Birth: June 12, 1957

Contact Information Page

Mailing Address

Mailing Address: 1234 W. JONES AVENUE APARTMENT 215 TAMPA FL 32222

Reside at this address: Yes

Phone and email

Daytime telephone number: (321) 8111-1234

Type of phone: Other

Best time to call: Noon to 5 p.m.

Email address:

Language preferences

Preferred language for speaking: English

Preferred language for reading: English

Birth and Citizenship Information Page

Born in the United States or a U.S. territory or commonwealth: Yes

City of Birth: Washington

State of Birth: DISTRICT OF COLUMBIA

US Citizen: Yes

Type of Citizenship: US Citizen born inside US

Confirmation Number

The confirmation number is: 12345678

Initial Information Section:

Note: (New page prior to the Application Number page)

Medicare question: Do you wish to file for Medicare Only, excluding all cash benefits: YES

Medicare question: Are you already enrolled in Medicare under a social security number other than your own: NO

Benefit Information Page:

Do you want to enroll in Medicare Part B: YES

Are you receiving Medicaid: YES

Note: The following is based on if the Medicaid question is answered yes

What is your Medicaid (state health insurance) number: 1234567 or I don't know my Medicaid (state insurance) number.

What state provides you with Medicaid (state health insurance): MD

When did your Medicaid (state health insurance) start: 5/2007

Has your Medicaid (state health insurance) ended: (If "yes" then follow-up question)

When did your state health insurance end: 3/2008



Are you covered under an employer sponsored group health Plan: (If “yes” then follow-up question)

Is this coverage from- Own Employment/Spouse or Other Employment: Own Employment

Employment Information:

What date did employment start: April 27, 1973

Has employment ended: YES

What date did employment end: March 13,2009

Health Insurance Coverage:

What date did coverage start: June 1973

Has coverage ended: YES

What date did coverage end: March 2009

Remarks Page

Remarks: Claimant has estimated the exact dates of her employment and group health plan coverage

**Remarks:**

RMK001

RMK002

I understand I must file a separate application when I wish to establish entitlement to monthly Social Security benefits.

AFB079  
New text  
for M0

I declare under penalty of perjury that I have examined all the information on this application and it is true and correct to the best of my knowledge.

AFB064

Signature \_\_\_\_\_ Date \_\_\_\_\_

AFB060

Witnesses are required only if this application has been signed by mark (x) above. If signed by (x), two witnesses to the signing who know the applicant must sign below, giving their full addresses.

AFB061

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Signature of Witness

CA401M

\_\_\_\_\_  
Number and Street Address  
Address

\_\_\_\_\_  
Number and Street

\_\_\_\_\_  
City, State, and Zip Code  
Code

\_\_\_\_\_  
City, State, and Zip

This form should be submitted to the address shown on your notice.

**Privacy Act Statement**

AFB062

The Social Security Administration (SSA) is allowed to collect the facts on this form under Section 205 of the Social Security Act. We need this information to efficiently process your application. Giving us this information is voluntary. However, without them we may not be able to process your application. While the information you furnish on this form would almost never be used for any purpose other than the intended use of this form, such information may be disclosed by SSA as generally permitted under 5 U.S.C. sec. 552a(b) of the Privacy Act of 1974, as amended. This includes using the information as necessary for administrative purposes or as authorized by routine uses in the applicable Privacy Act system of records. SSA has access to the information you provide on this application and is authorized to keep even information on applications that were partially completed. This is for purposes of helping you complete the application process. Explanations about possible reasons why information you provide us may be used or given out are available upon request from any Social Security office.

**Paperwork Reduction Act Statement**

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. sec. 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to review, confirm or sign this application summary unless we display a valid Office of Management and Budget control number; the control number is 0960-0618. We estimate that it will take about 20 minutes to read the instructions, review the

AFB063

information contained in the summary, and sign the application. 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.