(Do not write in this space)

APPLICATION FOR BENEFITS UNDER A U.S. INTERNATIONAL SOCIAL SECURITY AGREEMENT

If the worker is living, this application should be completed by or on behalf of the worker. If the worker is deceased, this application should be completed by one of the worker's survivors who is claiming benefits under the provisions of the international social security agreement.

PART 1

Complete Part 1 in all cases.

1.	(a) Print name of worker (First name, middle initial, last name)	(b) U.S. Social Security Number

2. Provide the following information about the worker's social security credits (coverage) and last place of residence in the foreign country.

(a) Use columns (1) - (5) to enter information about the worker's periods of employment or self-employment in the foreign country. *(If additional space is required, enter the information in Remarks -- item 19.)*

(1) Dates worked (From - To)	(2) Name and address of employer or self-employment activity	(3) Type of industry or business	(4) Social insurance number used while working	(5) Name of Agency to which contributions paid

(b) Use columns (1) - (4) to enter information about the worker's periods of coverage under the foreign social insurance system that are not based on employment or self-employment (e.g., coverage for voluntary contributions, deemed or equivalent coverage, periods of military service, illness, etc.)

(1) Dates covered (From - To)	(2) Type of coverage	(3) Social insurance number used for this coverage if different than shown in item 2(a)(4)	(4) Name of Agency to which contributions paid (if any)

(c) Enter the worker's last place of residence in the foreign country:

(City and State or Province)

PLEASE REMOVE PAGE 1 OF THIS FORM BEFORE COMPLETING THE REST OF THE APPLICATION. AFTER APPLICATION IS COMPLETED AND SIGNED, STAPLE DETACHED PAGE TO APPLICATION.

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3. I apply for benefits under the provisions of the social security agreement between the United States and | Name of country

4. This application may be used to claim benefits from the U.S. and/or the foreign country shown in item 3. Check (X) the block (s) indicating the type of benefit(s) for which you are in under the country(ies) from which you are claiming the benefit(s).

BENEFIT CLAIMED FROM FOREIGN COUNTRY

Type of Benefit Claimed From Foreign Country:

☐ Retirement/Old-Age ☐ Survivors ☐ None

☐ Disability or Sickness/Invalidity ☐ Other (Specify) _____

BENEFIT CLAIMED FROM THE UNITED STATES

(a) Are you presently receiving benefits from the United States? ☐ Yes *(If "Yes" answer (b) below.)* ☐ No *(If "No" answer (c) below.)*

(b) If you are already receiving U.S. benefits, do you wish to file for a different type of U.S. benefit? *(If "Yes" indicate the type of benefit you wish to claim from the U.S.)* ☐ Yes ☐ No *(If "No" go on to item 5.)*

☐ Retirement ☐ Disability ☐ Survivors

(c) If you are not presently receiving U.S. benefits, do you wish to file for U.S. benefits at this time? *(If "Yes" indicate the type of benefit you wish to claim from the U.S.)* ☐ Yes ☐ No *(If "No" go on to item 5.)*

☐ Retirement ☐ Disability ☐ Survivors

INFORMATION ABOUT THE WORKER

5. (a) Print worker's name at birth, if different from item 1(a)

(b) Check (X) one for the worker

☐ Male ☐ Female

(c) Enter worker's social insurance number in the foreign country if different than shown in items 2(a)(4) or 2(b)(3)

(d) If the worker's Social Security number in either the United States or the foreign country is not known, enter the worker's parents' names:

Mother's name (First name, middle initial, last name, maiden name)

Father's name (First name, middle initial, last name)

(e) Enter the worker's citizenship (Enter name of country)

6. Do you want this application to protect an eligible spouse's and/or child's right to social security benefits? ☐ Yes ☐ No

7. (a) Was the worker or any other person claiming benefits on this application a refugee or stateless person at any time? ☐ Yes *(If "Yes" answer (b) below.)* ☐ No *(If "No" go on to item 8.)*

(b) If "Yes" enter the following information about the person:

Name	Dates of refugee or stateless status

PART 2

Complete Part II ONLY if you are claiming benefits from a foreign country.

8.	If you are applying for sickness or disability/invalidity benefits, enter the date you became disabled. Otherwise enter "N/A."	Date (MM/DD/YYYY)
9.	(a) If you are applying for retirement/old-age benefits, have you stopped or do you plan to stop working? ☐ Yes *(If "Yes" answer (b) below.)* ☐ No *(If "No" go on to item 10.)*	
	(b) If "Yes," enter the date you stopped or plan to stop working.	Date (MM/DD/YYYY)
10.	(a) Are you applying for foreign social security benefits under a special system that covers a specific occupation (e.g., miners, seamen, farmers)? ☐ Yes *(If "Yes" answer (b) and (c) below.)* ☐ No *(If "No" go on to item 11.)*	
	(b) What was your occupation in the foreign country?	
	(c) Did you perform the same type of work in the U.S? ☐ Yes ☐ No	

INFORMATION ABOUT THE APPLICANT

Complete item 11 ONLY if you are not the worker. If you are the worker, leave this question blank and go on to item 12.

11.	(a) Print your name (First name, middle initial, last name, maiden name)	(b) What is your relationship to the worker?
	(c) Enter your U.S. Social Security number	(d) Enter your social insurance number in the foreign country *(if none or unknown, so indicate)*

ADDITIONAL INFORMATION ABOUT THE WORKER

12.	(a) Enter worker's date of birth (MM/DD/YYYY)	(b) Enter worker's place of birth *(City, state, province, country)*	
13.	If the worker is deceased, enter the date and place of death	(a) Date (MM/DD/YYYY)	(b) Place *(City, state, province, country)*

14.	(a) Was the worker in the active military or naval service of the U.S. (including Reserve, National Guard active duty or active duty for training) or a foreign country after September 7, 1939? ☐ Yes *(If "Yes" answer (b) thru (c) below.)* ☐ No *(If "No"go on to item 15.)*			
	(b) Enter the name of country served and dates of service:	Country	Dates of Service FROM: *(MM/DD/YYYY)*	TO: *(MM/DD/YYYY)*
	(c) Has anyone (living or deceased) received, or does anyone expect to receive, a benefit from any U.S. Federal agency based on the worker's military or naval service? ☐ Yes *(If "Yes" answer (d) below* ☐ No *(If "No" go on to item 15*			

(d) If "Yes" enter the following information for each person: (If additional space is required, enter the information in Remarks -- item 19)

Name	U. S. Agency	Claim No.

15. (a) During the past 24 months, did the worker engage in employment or self-employment covered by the U.S. Social Security system? ☐ Yes ☐ No

(If "Yes" answer (b) and (c) below.) *(If "No" go on to item 16.)*

List the periods of work covered by the U.S. Social Security system and the name and address of the employer or self-employment activity

(b) Name and address of employer or self-employment activity	Work Began (Month-Year)	Work Ended (Month-Year)

(c) May we ask any employer listed above for wage information needed to process this claim? ☐ Yes ☐ No

INFORMATION ABOUT DEPENDENTS FOR WHOM BENEFITS ARE CLAIMED

16. (a) Are there any children of the worker who are now, or were in the past 12 months, unmarried and:

Under age 18 ☐ Yes ☐ No

OR

Age 18 or over and a student or disabled ☐ Yes ☐ No

If either block is checked "Yes", enter the information for each child. NOTE: Children include natural children, step-children and adopted children plus grandchildren living in the same household as the worker.

(b) Name of child	(c) Relationship to worker	(d) Sex (M or F)	(e) Date of birth (MM/DD/YYYY)

17. The spouse, widow or widower of the worker may be eligible for a benefit. In addition, a former spouse of the worker may be eligible as a divorced spouse, widow or widower. Provide the following information about any spouse or former spouse of the worker.

	SPOUSE	FORMER SPOUSE	FORMER SPOUSE
(a) Name (including maiden name)			
(b) Date of Birth (MM/DD/YYYY)			
(c) Date of Marriage (MM/DD/YYYY)			
(d) Date of Divorce (if any) (MM/DD/YYYY)			
(e) Country of Citizenship			
(f) Social Insurance Number in foreign country			
(g) U. S. Social Security Number (if any)			

18. (a) Has the worker, or any other person listed on this application, ever previously applied for U.S. Social Security benefits or social insurance benefits from the country shown in item 3 of this application? ☐ Yes ☐ No

(If "Yes" answer (b) thru (f) below.) *(If "No" go on to item 19.)*

If "Yes" enter the information requested for each person. *(If additional space is required, enter the information in Remarks -- item 19.)*

(b) Name	(c) Type of benefit (e.g., Retirement)

(d) Claim Number	(e) Amount of benefit (if benefit awarded)	(f) Agency which approved or denied claim

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

I hereby authorize the United States to furnish to the competent social insurance agency of the other country all of the information and evidence in its possession which relates or could relate to this application for benefits. I also authorize the agency(ies) of the other country to furnish the Social Security Administration or a United States Foreign Service post all of the information and evidence in its possession which relates to this application for benefits.

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 (MM/DD/YYYY)
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)

Mailing Address *(Number and street, Apt. No., P.O. Box, or Rural Route)* (Enter resident address in "Remarks" if different)

City and State	ZIP Code	Country *(if any)* in which you now live

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 Statement
Collection and Use of Personal Information

Sections 205(a), 205(c)(2), and 233 of the Social Security Act, as amended, allow us to collect this information. Furnishing us this information is voluntary. However, failing to provide all or part of the information may prevent an accurate and timely decision on your claim.

We will use the information to determine your eligibility for benefits under a Totalization agreement. We may also share your information for the following purposes, called routine uses:

1. To the Social Security Agency of a foreign country, to carry out the purpose of an international Social Security agreement entered into between the United States and the other country, pursuant to section 233 of the Social Security Act.

2. To any source that has, or is expected to have, information that the Social Security Administration needs in order to establish or verify a person's eligibility for a certificate of coverage under a Social Security agreement authorized by section 233 of the Social Security Act.

In addition, we may share this information in accordance with the Privacy Act and other Federal laws. For example, where authorized, we may use and disclose this information in computer matching programs, in which our records are compared with other records to establish or verify a person's eligibility for Federal benefit programs and for repayment of incorrect or delinquent debts under these programs.

A list of additional routine uses is available in our Privacy Act System of Records Notice (SORN) 60-0059, entitled Earnings Records and Self Employment Income System, and 60-0090, entitled Master Beneficiary Record. Additional information and a full listing of all our SORNs are available on our website at www.socialsecurity.gov/foia/bluebook.

~~Paperwork Reduction Act Statement~~ See Revised PRA Statement Attached

~~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 XX 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.***~~