

**MARRIAGE CERTIFICATION**

**SEE PAPERWORK/PRIVACY  
ACT NOTICE ON REVERSE.**

PRINT NAME OF WAGE EARNER OR SELF-EMPLOYED PERSON

SOCIAL SECURITY NUMBER

I am the spouse of the person named below, who has applied for insurance benefits under Title II of the Social Security Act, as presently amended.

NAME OF SPOUSE (First Name)

(Maiden Name, if applicable)

(Last Name)

1. Indicate whether your present marriage was performed by:

Clergyman or Authorized Public Official  Other (Explain)

2. Were you married before your present marriage?

Yes  No

(If "yes", give the following information about each of your previous marriages.)

**PREVIOUS MARRIAGE**

TO WHOM MARRIED

WHEN (Month, Day, Year)

WHERE (City and State)

HOW MARRIAGE ENDED

WHEN (Month, Day, Year)

WHERE (City and State)

MARRIAGE PERFORMED BY:

Clergyman or Public Official  
 Other (Explain in "REMARKS")

SPOUSE'S DATE OF BIRTH (or age)

GIVE DATE OF DEATH IF SPOUSE IS DECEASED

Spouse's Social Security Number  
(If none or unknown, so indicate)

**PREVIOUS MARRIAGE**

TO WHOM MARRIED

WHEN (Month, Day, Year)

WHERE (City and State)

HOW MARRIAGE ENDED

WHEN (Month, Day, Year)

WHERE (City and State)

MARRIAGE PERFORMED BY:

Clergyman or Public Official  
 Other (Explain in "REMARKS")

SPOUSE'S DATE OF BIRTH (or age)

GIVE DATE OF DEATH IF SPOUSE IS DECEASED

Spouse's Social Security Number  
(If none or unknown, so indicate)

REMARKS: (Use this space of this form for information about any other previous marriages, if necessary)

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 WAGE EARNER OR SELF-EMPLOYED PERSON SIGNATURE (First Name, Middle Initial, Last Name) (Write in ink.)		DATE (Month, Day, Year)
		TELEPHONE NUMBER (Area Code)
MAILING ADDRESS (Number and Street, Apt. No., P.O. Box, or Rural Route)		
CITY	STATE	ZIP CODE

Witnesses are required ONLY if this statement has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the wage earner or self-employed person 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)

### Privacy Act Statement Collection and Use of Personal Information

Section 205(a) of the Social Security Act, as amended, [42 U.S.C. 405(a)] authorizes us to collect this information. We will use the information you provide to help us determine the identity of your spouse. The information you furnish on this form is voluntary. However, failure to provide the requested information may prevent us from paying benefits to your spouse.

**See Revised Privacy Act Statement Attached**

We rarely use the information you supply for any purpose other than for determining the identity of a spouse. However, we may use it for the administration and integrity of Social Security programs. We may also disclose information to another person or to another agency in accordance with approved routine uses, which include but are not limited to the following:

1. To enable a third party or an agency to assist Social Security in establishing rights to Social Security benefits and/or coverage; 2. To comply with Federal laws requiring the release of information from Social Security 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 and audit activities necessary to assure the integrity and improvement of Social Security programs (e.g., to the Bureau of the Census and private entities under contract with us).

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. We use the information from these matching 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 for this information is available in our Systems of Records Notices entitled Claims Folders Systems, 60-0089 and Master Beneficiary Record 60-0090. The notices, additional information regarding this form, and information regarding our systems and programs, are available on-line at [www.ssa.gov](http://www.ssa.gov) or at any local Social Security office.

**See Revised PRA Attached**

**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 5 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](http://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.**