APPLICATION FOR PARENT'S INSURANCE BENEFITS*

(Do not write in this space)

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

*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.) For additional information about this application a factsheet to Form SSA-7 is available at www.socialsecurity.gov

1.	(a) PRINT name of deceased wage earner or self-employed person (herein referred to as the "Deceased.")	FIRST NAME, MIDDLE INITIAL, LAST NAME
	(b) Check (X) one for the Deceased.	☐ Male ☐ Female
	(c) Enter Deceased's Social Security number.	
2.	(a) PRINT your name.	FIRST NAME, MIDDLE INITIAL, LAST NAME
	(b) Enter your Social Security number.	
	(c) Enter your name at birth if different from item 2(a).	
3.	(a) Were you receiving at least one-half of your support from the Deceased at the time the Deceased became disabled under the Social Security law or at the time of death?	☐ Yes (If "Yes," answer (b).) ☐ No (If "No," go on to item 4.)
	(b) Have you filed proof of this support with the Social Security Administration?	☐ Yes ☐ No

PART 1 - INFORMATION ABOUT THE DECEASED

4.	Enter date of birth of Deceased.	MONTH, DAY, YEAR
5.	(a) Enter date of death.	MONTH, DAY, YEAR
	(b) Enter place of death.	CITY AND STATE
6.	(a) Did the Deceased 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 ***(If "Yes," answer (b) and (c).)*** ☐ No ☐ Unknown ***(If "No" or "Unknown" go on to item 7.)***
	(b) Enter name of person on whose Social Security record other application was filed.	FIRST NAME, MIDDLE INITIAL, LAST NAME
	(c) Enter Social Security number of person named in (b), (If "Unknown," so indicate.)	

Answer Item 7 ONLY if the Deceased Died Prior to Full Retirement Age or Prior to One Year Past Full Retirement Age, and Within the Past 4 Months.

7.	(a) Was the Deceased unable to work because of a disabling condition at the time of death?	☐ Yes ***(If "Yes," answer (b).)*** ☐ No ***(If "No," go on to item 8.)***
	(b) Enter date disability began.	MONTH, DAY, YEAR

8.	(a) Was the Deceased 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?	☐ Yes ***(If "Yes," answer (b) and (c).)***	☐ No ***(If "No," go on to item 9.)***
	(b) Enter dates of service.	From: (Month, year)	To: (Month, year)
	(c) Have you received, or do you expect to receive, a benefit from any other Federal agency?	☐ Yes	☐ No

Answer Item 9 ONLY If Death Occurred Within the Last 2 Years.

9.	(a) About how much did the Deceased earn from employment and self-employment during the year of death?	AMOUNT $ _____	☐ Unknown
	(b) About how much did the Deceased earn the year before death?	AMOUNT $ _____	☐ Unknown
10.	(a) Did the deceased have wages or self-employment income covered under Social Security in all years from 1978 through last year?	☐ Yes ***(If "Yes," skip to item 11.)***	☐ No ***(If "No," answer (b).)***
	(b) List the years from 1978 through last year in which the deceased did not have wages or self-employment income covered under Social Security.		
11.	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.		

PART 2 - INFORMATION ABOUT YOURSELF

12.	(a) Enter date of birth.	MONTH, DAY, YEAR		
	(b) Enter name of State or Foreign country where you were born.			
	If you have already presented, or if you are now presenting, a public or religious record of your birth established before you were age 5, go on to item 13.			
	(c) Was a public record of your birth made before you were age 5?	☐ Yes	☐ No	☐ Unknown
	(d) Was a religious record of your birth made before you were age 5?	☐ Yes	☐ No	☐ Unknown
13.	(a) Have you married since the death of the Deceased?	☐ Yes	☐ No	

(b) Enter below the information requested about the marriage.

To whom married	When (Month, day, year)	Where (Name of City and State)
How marriage ended (If still in effect, write "Not Ended")	When (Month, day, year)	Where (Name of City and State)

Marriage performed by:

☐ **Clergyman or public official**	Spouse's date of birth (or age)	If spouse deceased, give date of death
☐ **Other (Explain in "Remarks")**		

Spouse's Social Security Number (If "None" or "Unknown," so indicate)

14.	(a) Have you ever filed an application for Social Security benefits, a period of disability under Social Security, Supplemental Security Income, or hospital or medical insurance under Medicare?	☐ **Yes** ***(If "Yes," answer (b) and (c).)***	☐ No ***(If "No," go on to item 15.)***

	(b) Enter name of person on whose Social Security record you filed other application.		
	(c) Enter Social Security number of person named in (b). ***(If "Unknown," so indicate.)***		
15.	Were you 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?	☐ Yes	☐ No
16.	Did you, your spouse, or the Deceased work in the railroad industry for 5 years or more?	☐ Yes	☐ No
17.	(a) Do you have social security credits (for example, based on work or residence) under another country's social security system?	☐ Yes **(If "Yes," answer (b).)**	☐ No **(If "No," go on to item 18.)**
	(b) List the country(ies).		

Answer Item 18 ONLY if the Deceased Died Before This Year.

18.	(a) How much were your total earnings last year?	**$**			
	(b) Place an "X" in each block for EACH MONTH of last year in which you did not earn more than *$ _____ in wages, and did not perform substantial services in self-employment. These months are exempt months. If no months were exempt months, place an "X" in "NONE". If all months were exempt months, place an "X" in "ALL". *Enter the appropriate monthly limit after reading the instructions, "How Your Earnings Affect Your Benefits".	NONE		ALL	
		Jan.	Feb.	Mar.	Apr.
		May	Jun.	Jul.	Aug.
		Sept.	Oct.	Nov.	Dec.
19.	(a) How much do you expect your total earnings to be this year?	**$**			
	(b) Place an "X" in each block for EACH MONTH of last year in which you did not earn or will not earn more than *$ _____ in wages, and did not or will not perform substantial services in self-employment. These months are exempt months. If no months are or will be exempt months, place an "X" in "NONE". If all months are or will be exempt months, place an "X" in "ALL". *Enter the appropriate monthly limit after reading the instructions, "How Your Earnings Affect Your Benefits".	NONE		ALL	
		Jan.	Feb.	Mar.	Apr.
		May	Jun.	Jul.	Aug.
		Sept.	Oct.	Nov.	Dec.

Answer This Item ONLY if You Are Not in the Last 4 Months of Your Taxable Year (Sept., Oct., Nov., and Dec., if Your Taxable Year is a Calendar Year).

20.	(a) How much do you expect to earn next year?	**$**			
	Place an "X" in each block for EACH MONTH of next year in which you do not expect to earn more than *$ _____ in wages, and do not expect to perform substantial services in self-employment. These months will be exempt months. If no months are expected to be exempt months, place an "X" in "NONE". If all months are expected to be exempt months, place an "X" in "ALL". *Enter the appropriate monthly limit after reading the instructions, "How Your Earnings Affect Your Benefits".	NONE		ALL	
		Jan.	Feb.	Mar.	Apr.
		May	Jun.	Jul.	Aug.
		Sept.	Oct.	Nov.	Dec.
21.	If you use a fiscal year, that is, a taxable year that does not end December 31 (with income tax return due April 15) enter here the month your fiscal year ends.	MONTH			

MEDICARE INFORMATION

If this claim is approved and you are still entitled to benefits at age 65, or you are within 3 months of age 65 or older you could automatically receive Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance) coverage at age 65. If you are not eligible for automatic enrollment in Medicare Part B, you will need to contact Social Security to request enrollment.

(Turn to Page 4)

Complete Item 22 ONLY If You Are Within 3 Months of Age 65 or Older

Medicare Part B (Medical Insurance) helps cover doctor's services and outpatient care. It also covers some other services that Medicare Part A doesn't cover, such as some of the services provided by physical and occupational therapists and some home health care. If you enroll in Medicare Part B, you will have to pay a monthly premium. The amount of your premium will be determined when your coverage begins. In some cases, your premium may be higher based on information about your income we receive from the Internal Revenue Service. Your premiums will be deducted from any monthly Social Security, Railroad Retirement, or Office of Personnel Management benefits you receive. If you do not receive any of these benefits, you will get a letter explaining how to pay your premiums. You will also get a letter if there is any change in the amount of your premium.

Late Enrollment Penalty

If you do not sign up for Part B when you are first eligible, you may have to pay a late enrollment penalty for as long as you have Part B. Your monthly premium for Part B may go up 10% for each full 12-month period that you could have had Part B, but did not sign up for it. Also, you may have to wait until the General Enrollment Period (January 1 to March 31) to enroll in Part B, and coverage will start July 1 of that year.

You can also enroll in a Medicare prescription drug plan (Part D). To learn more about the Medicare prescription drug plans and when you can enroll visit www.medicare.gov or call 1-800-MEDICARE (1-800-633-4227; TTY 1-877-486-2048). A Medicare Representative can also tell you about agencies in your area that can help you choose your prescription drug coverage.

If you have limited income and resources, we encourage you to apply for the Extra Help that is available to assist you with Medicare prescription drug costs. The Extra Help can pay the monthly premiums, annual deductibles, and prescription co-payments. To learn more or apply, please visit www.socialsecurity.gov, call 1-800-772-1213 (TTY 1-800-325-0778) or visit the nearest Social Security office.

22.	Do you want to enroll in Medicare Part B (Medical Insurance)? Select "No" if you are already enrolled under your own Social Security Number.	☐ Yes ☐ No

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)** **SIGN HERE**	Telephone number(s) at which you may be contacted during the day (AREA CODE)

FOR OFFICIAL USE ONLY	Direct Deposit Payment Address *(Financial Institution)*			
	Routing Transit Number	C/S	Depositor Account Number	☐ No Account ☐ 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

Witnesses are required ONLY if this application has been signed by mark (X) above. If signed by mark (X), two witnesses 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, 223, 226, and 806 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 us from making an accurate and timely decision on your entitlement to Social Security benefit payments.

We will use the information to determine your eligibility for Social Security benefits. We may also share your information for the following purposes, called routine uses:

- To Federal, State, or local agencies (or agents on their behalf) for administering income maintenance or health maintenance programs (including programs under the Social Security Act). Such disclosures include, but are not limited to, release of information to: Railroad Retirement Board for administering provisions of the Railroad Retirement Act relating to railroad employment; for administering the Railroad Unemployment Insurance Act and for administering provisions of the Social Security Act relating to railroad employment; and Department of Veterans Affairs for administering 38 U.S.C. 1312, and upon request, for determining eligibility for, or amount of, veterans benefits or verifying other information with respect thereto pursuant to 38 U.S.C. 5106; and

- To contractors and other Federal agencies, as necessary, for the purpose of assisting the Social Security Administration (SSA) in the efficient administration of its programs. We will disclose information under the routine use only in situations in which SSA may enter into a contractual or similar agreement with a third party to assist in accomplishing an agency function relating to this system of records.

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 Notices (SORN) 60-0059, Earnings Recording and Self-Employment Income System, as published in the Federal Register (FR) on January 11, 2006, at 71 FR 1819; 60-0089, entitled Claims Folders Systems, as published in the FR on April 1, 2003, at 68 FR 15784; 60-0090, entitled Master Beneficiary Record, as published in the FR on January 11, 2006, at 71 FR 1826; and 60-0321, entitled Medicare Database, as published in the FR on July 25, 2006, at 71 FR 42159. Additional information and a full listing of all our SORNs are available on our website at www.ssa.gov/privacy.

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. The OMB control number for this collection is 0960-0012. We estimate that it will take 15 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 PARENT'S INSURANCE BENEFITS

TELEPHONE NUMBER(S) TO CALL IF YOU HAVE A QUESTION OR SOMETHING TO REPORT	**BEFORE** YOU RECEIVE A NOTICE OF AWARD _____ AREA CODE **AFTER** YOU RECEIVE A NOTICE OF AWARD _____ AREA CODE	SSA OFFICE	DATE CLAIM RECEIVED

Your application for Social Security benefits has been received and will be processed as quickly as possible.

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 have a change of 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

DECEASED'S NAME (If surname differs from name of claimant)

CHANGES TO BE REPORTED AND HOW TO REPORT

FAILURE TO REPORT MAY RESULT IN OVERPAYMENTS THAT MUST BE REPAID, AND IN POSSIBLE MONETARY PENALTIES

- You change your 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.)
- Your citizenship or immigration status changes.
- You go 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 you expect total earnings for_____ to be $ _____ .

You ☐ (are) ☐ (are not) earning wages of more than $_____ a month.

You ☐ (are) ☐ (are not) self-employed rendering substantial services in a trade or business.

(Report AT ONCE if this work pattern changes.)

- You are confined to jail, prison, penal institution or correctional facility for more than 30 continuous days for a conviction of a crime or you are confined for more than 30 continuous days to a public institution by court order in connection with a crime.
- You have an unsatisfied felony or arrest warrant for more than 30 continuous days for flight to avoid prosecution or confinement, escape from custody or flight escape.
- Change of Marital Status - Marriage, divorce, annulment of marriage. You must report marriage even if you believe that an exception applies.
- Custody Change - Report if a person for whom you are filing, or who is in your care dies, leaves your care or custody, or changes address.

WORK AND EARNINGS

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 you earn more than the annual exempt amount. You may contact SSA to file a report. Otherwise, SSA will use the earnings reported by your employer(s) and your self-employment tax return (if applicable) as the report of earnings required by law and adjust benefits under the earnings test. It is your responsibility to ensure that the information you give concerning your earnings is correct. You must furnish additional information as needed when your benefit adjustment is not correct based on the earnings on your record.

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:

- 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 shown on your claim receipt.

For general information about Social Security, visit our web site at www.socialsecurity.gov.