REVISIONS TO FORM (blue circle) Represents Change # on the Addendum

#1

APPLICATION FOR SOCIAL SECURITY **BENEFITS***

(Do not write in this space)

#2

With this application, you are applying for all insurance benefits for which you are 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. The information you furnish on this application will ordinarily be sufficient for a determination on the lump-sum death payment. If you were receiving spouse's benefits at the time of your spouse's death, you only need to complete the circled items. All other claimants must complete the entire form."This may serve as 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).

(1.)(a) PRINT name of deceased wage earner or self-employed person (herein referred to as the "deceased")	FIRST NAME, MIDDLE INITIAL, LAST NAME
#3 (XXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
(b) 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)	FIRST NAME, MIDDLE INITIAL, LAST NAME

PART I - INFORMATION ABOUT THE DECEASED

3. Enter date of birth of deceased	MONTH, DAY, YEAR
(4.)(a) Enter date of death	MONTH, DAY, YEAR
(b) Enter place of death	CITY AND STATE
(5.)Enter name of the State or foreign country where the deceased had a fixed, permanent home at the time of death.	

#4

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Answer Item 6 Only if the Deceased Died Prior to Full Retirement Age or Prior to 1 Year Past Full Retirement Age, and Within the Past 4 Months.

6 (a) Was the deceased unable to work because of illnesses, injuries or conditions at the time of death?	☐ Yes (If "Yes," answer (b).)	☐ No (If "No," go on to item 7)
(b) Enter the date the deceased became unable to work.	MONTH,DAY,YEAR	

#5

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ANSWER ITEM 7 ONLY IF DEATH OCCURRED WITHIN THE LAST 2 YEARS.

#6

7. (a) How much did the deceased earn from employment and self-employment during the year of death?	Amount $
(b) How much did the deceased earn the year before death?	Amount $
8. (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 9.) ☐ 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.	

9. 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.

INFORMATION ABOUT THE DECEASED'S MARRIAGE(S)

10. Answer this item ONLY if the deceased had other marriages.

(a) If the deceased married **after** his or her marriage to you, enter the information on the last marriage. **(If none, write "NONE".)**

Spouse's Name *(including maiden name)*	When *(Month, Day, and Year)*	Where *(Name of City and State)*
How Marriage Ended	When *(Month, Day, and Year)*	Where *(Name of City and State)*
Marriage performed by ☐ Clergyman or public official ☐ Other *(Explain in Remarks)*	Spouse's date of birth (or age)	If spouse deceased, give date of death
Spouse's Social Security Number *(If none or unknown, so indicate)*		

(b) If the deceased had any other marriages, and the marriage lasted at least 10 years or ended due to death of the spouse (whether before or after you married the deceased), enter the information below. If the deceased divorced then remarried the same individual within the year immediately following the year of the divorce, and the combined period of marriage totaled 10 years or more, include the marriage. **(If none, write "NONE".)**

Spouse's Name *(including maiden name)*	When *(Month, Day, and Year)*	Where *(Name of City and State)*
How Marriage Ended	When *(Month, Day, and Year)*	Where *(Name of City and State)*
Marriage performed by ☐ Clergyman or public official ☐ Other *(Explain in Remarks)*	Spouse's date of birth (or age)	If spouse deceased, give date of death
Spouse's Social Security Number *(If none or unknown, so indicate)*		

USE "REMARKS" SPACE ON BACK PAGE FOR INFORMATION ABOUT ANY OTHER MARRIAGE AS DESCRIBED IN 10b.

11. Is there a surviving parent (or parents) who was receiving support from the deceased at the time of death or at the time the deceased became disabled under Social Security Law? ☐ Yes (If "Yes," enter the name and address in"Remarks.")

PART II - INFORMATION ABOUT YOURSELF

#7

12. (a) Enter name of State or foreign country where you were born.

#8

13. (a) Are you a U.S. citizen YES NO

(b) Are you an alien lawfully present in the U.S.? YES NO

If yes, when were you lawfully admitted into the U.S.? _____

REVISIONS TO FORM Represents Change # on the Addendum

INFORMATION ABOUT YOUR MARRIAGE(S)

14. (a) Enter information about your marriage to the deceased.

Spouse's Name *(including maiden name)*	When *(Month, Day, and Year)*	Where *(Name of City and State)*
How Marriage Ended	**When *(Month, Day, and Year)***	**Where *(Name of City and State)***
Marriage performed by ☐ Clergyman or public official ☐ Other *(Explain in Remarks)*	**Spouse's date of birth (or age)**	**If spouse deceased, give date of death**
Spouse's Social Security Number *(If none or unknown, so indicate)*		

(b) If you remarried **after** the marriage shown in 14a enter information about the last marriage. **(If none, write "NONE".)**

Spouse's Name *(including maiden name)*	When *(Month, Day, and Year)*	Where *(Name of City and State)*
How Marriage Ended	**When *(Month, Day, and Year)***	**Where *(Name of City and State)***
Marriage performed by ☐ Clergyman or public official ☐ Other *(Explain in Remarks)*	**Spouse's date of birth (or age)**	**If spouse deceased, give date of death**
Spouse's Social Security Number *(If none or unknown, so indicate)*		

(c) Enter information about any other marriage you may have had that lasted at least 10 years (see item 14b for counting consecutive multiple marriages to the same individual) or ended due to death of the spouse (whether before or after you married the deceased). **(If none, write "NONE".)**

Spouse's Name *(including maiden name)*	When *(Month, Day, and Year)*	Where *(Name of City and State)*
How Marriage Ended	**When *(Month, Day, and Year)***	**Where *(Name of City and State)***
Marriage performed by ☐ Clergyman or public official ☐ Other *(Explain in Remarks)*	**Spouse's date of birth (or age)**	**If spouse deceased, give date of death**
Spouse's Social Security Number *(If none or unknown, so indicate)*		

***USE "REMARKS" SPACE ON BACK PAGE FOR INFORMATION ABOUT ANY OTHER MARRIAGE AS DESCRIBED IN 14c**

IF YOU ARE APPLYING FOR SURVIVING DIVORCED SPOUSE'S BENEFITS, OMIT 15 AND GO ON TO ITEM 16

15. (a) Were you and the deceased living together at the same address when the deceased died? ☐ Yes (If "Yes," go to item 16) ☐ No No(If "No," answer (b).)

(b) If either you or the deceased were away from home (whether or not temporarily) when the deceased died, give the following: Who was away? ☐ Deceased ☐ Surviving Spouse

Date last at home:	Reason absence began:	Reason you were apart at time of death:

If separated because of illness, enter nature of illness or disabling condition.

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#9

REVISIONS TO FORM — Represents Change # on the Addendum

DO NOT ANSWER QUESTION 16 IF YOU ARE FULL RETIREMENT AGE OR OLDER. GO ON TO QUESTION 17

16. (a) Are you, or during the past 14 months have you been, unable to work because of illnesses, injuries or conditions?	☐ Yes (If "Yes," answer (b).)	☐ No (If "No," go on to item 17)
(b) Enter the date you became unable to work.	(Month, day, year)	

#5

1 XXX

17. Did you or the deceased work in the railroad industry for 5 years or more?	☐ Yes	☐ No
18. (a) Did you or the deceased 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 19)
(b) If "Yes," list the country(ies)	(c) Are you filing for foreign Social Security benefits?	
19. (a) Have you qualified for, or do you expect to qualify for, a pension or annuity (or a lump sum in place of a pension or annuity) based on your own employment and earnings for the Federal Government of the United States, or one of its States or local subdivisions that was not covered under Social Security? (Social Security benefits are not government pensions.)	☐ Yes (If "Yes," check which of the items in item (b) applies to you.)	☐ No (If "No," go on to item 20)

#10

(b)

☐ I receive a government pension or annuity.

☐ I received a lump sum in place of a government pension or annuity.

☐ I applied for and am awaiting a decision on my pension or lump sum.

☐ I have not applied for but I expect to begin receiving my pension or annuity:

(Month, day, year)
(If the date is not known, enter "Unknown".)

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 live in Puerto Rico or a foreign country, you are not eligible for automatic enrollment in Medicare Part B, and you will need to contact Social Security to request enrollment.

COMPLETE ITEM 20 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 of 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.

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). Medicare also can tell you about agencies in your area that can help you choose your prescription drug coverage. The amount of your premium varies based on the prescription drug plan provider. The amount you pay for Part D coverage may be higher than the listed plan premium, based on information about your income we receive from the Internal Revenue Service.

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.ssa.gov, call 1-800-772-1213 (TTY 1-800-325-0778) or visit the nearest Social Security office.

#13

20. Do you want to enroll in the Medicare Part B (Medical Insurance)?	☐ Yes	☐ No

REVISIONS TO FORM (1) Represents Change # on the Addendum

ANSWER ITEM 21 ONLY IF THE DECEASED DIED BEFORE THIS YEAR.

21 (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 information, "How Work Affects Your Benefits" (Publication No. 05-10069).

NONE ☐		ALL ☐	
Jan. ☐	Feb. ☐	Mar. ☐	Apr. ☐
May ☐	Jun. ☐	Jul. ☐	Aug. ☐
Sept. ☐	Oct. ☐	Nov. ☐	Dec. ☐

22. (a) How much do you expect your total earnings to be this year? $

(b) Place an "X" in each block for each month of this year in which you did not 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 information, "How Work Affects Your Benefits" (Publication No. 05-10069).

NONE ☐		ALL ☐	
Jan. ☐	Feb. ☐	Mar. ☐	Apr. ☐
May ☐	Jun. ☐	Jul. ☐	Aug. ☐
Sept. ☐	Oct. ☐	Nov. ☐	Dec. ☐

ANSWER ITEM 23 ONLY IF YOU ARE NOW IN THE LAST 4 MONTHS OF YOUR TAXABLE YEAR (SEPT., OCT., NOV., AND DEC., IF YOUR TAXABLE YEAR IS A CALENDAR YEAR).

23. (a) How much do you expect to earn next year? $

(b) 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 information, "How Work Affects Your Benefits."

NONE ☐		ALL ☐	
Jan. ☐	Feb. ☐	Mar. ☐	Apr. ☐
May ☐	Jun. ☐	Jul. ☐	Aug. ☐
Sept. ☐	Oct. ☐	Nov. ☐	Dec. ☐

24. 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

IF YOU ARE FULL RETIREMENT AGE OR OLDER, GO ON TO ITEM 26 OTHERWISE, PLEASE READ CAREFULLY THE INFORMATION ON PAGE 8 AND ANSWER ONE OF THE FOLLOWING ITEMS.

25. After reading the information on page 8, check one of thefollowing:

(a) I want benefits beginning with the earliest possible month. ☐

(b) I am full retirement age (or will be within 4 months) and I want benefits beginning with the earliest possible month, providing that there is no permanent reduction in my ongoing monthly benefits. ☐

(c) I want benefits beginning with _____ . I understand that either a higher initial payment or a higher continuing monthly benefit amount may be possible, but I choose not to take it. ☐

ANSWER QUESTION 26 ONLY IF YOU ARE NOW AT LEAST AGE 61 YEARS, 8 MONTHS.

26. Do you wish this application to be considered an application for retirement benefits on your own earnings record? ☐ Yes ☐ No

REVISIONS TO FORM Represents Change # on the Addendum

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

Direct Deposit Payment Address (Financial Institution)

Routing Transit Number	Account Number	☐ Checking	☐ Enroll in Direct Express
		☐ Savings	☐ Direct Deposit Refused

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 subject to fine or imprisonment, or both.

#11

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 AREA CODE

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	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)

REVISIONS TO FORM ⬭ Represents Change # on the Addendum

#1

RECEIPT FOR YOUR CLAIM FOR SOCIAL SECURITY XXXXXXXXXXXXXXXXXXXXXXXXXX **BENEFITS**

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

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 change your 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 on page 8. 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	DECEASED'S SURNAME IF DIFFERENT FROM CLAIMANT'S	Beneficiary Notice Control (BNC) Number

#12

PRIVACY ACT NOTICE
Collection and Use of Personal Information

Sections 202(e) and 202(f) of the Social Security Act, as amended, allow us to collect this information. Furnishing us this information is voluntary. However, failing to provide us with all or part of the information could prevent us from making an accurate and timely decision on your entitlement for widow or widower benefits.

We will use the information to make a determination for entitlement to widow or widower benefits. We may also share your information for the following purposes, called routine uses:

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

- To third party contacts, especially in situations where the party to be contacted has, or is expected to have, information relating to the individual' capability to manage his/her affairs or his/her eligibility for or entitlement to benefits under the Social Security program; when the data are needed to establish the validity of evidence; to verify the accuracy of information presented by the individual and, if it concerns his/her eligibility for benefits under the Social Security program.

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' 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) 60-0089, entitled Claims Folders System, as published in the Federal Register (FR) on April 1, 2003, at 68 FR 15784 and 60-0090 entitled Master Beneficiary Record, as published in the FR on January 11, 2006, at 71 FR 1826. Additional information, and a full listing of all our SORNs, is available on our website at www.ssa.gov/privacy.

#15

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 0960-0004. We estimate that it will take about 30 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.**

See Revised PRA Statement attached

SSA will insert the following revised PRA Statement into the form as soon as possible:

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 30 minutes to read the instructions, gather the facts, and answer the questions. ***Send only comments regarding this burden estimate or any other aspect of this collection, including suggestions for reducing this burden to*****:** *SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.*

REVISIONS TO FORM ⬭ Represents Change # on the Addendum

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 your trade or business.

(Report AT ONCE if this work pattern changes.)

- Change of Marital Status - Marriage, divorce, annulment of marriage. You must report a change in marital status even if you believe that an exception applies.
- You are confined for more than 30 continuous days to jail, prison, penal institution, or correctional facility for conviction of a crime or you are confined to a public institution by court order in connection with a crime.
- 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.
- You begin to receive a pension, annuity, or a lump sum payment based on your government employment not covered by Social Security or your pension or annuity amount changes or stops.
- You have an unsatisfied warrant for more than 30 continuous days for your arrest for a crime or attempted crime that is a felony or flight to avoid prosecution or confinement, escape from custody, and flight-escape. In most jurisdictions that do not classify crimes as felonies, this applies to a crime that is punishable by death or imprisonment for a term exceeding 1 year (regardless of the actual sentence imposed).

Disability Applicants

1. You return to work (as an employee or self-employed) regardless of amount of earnings.
2. Your condition improves.

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 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, in person, or online, 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 "Online Services" at our web site at www.ssa.gov #13
- 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 shown at the phone number and address on your claim receipt.

For general information about Social Security, visit our web site at www.ssa.gov #13

FIGURING YOUR YEARLY EARNINGS

To figure your total yearly earnings, count all gross wages (before deductions) and net earnings from self-employment which you earn during the entire year. This includes earnings both before and after your retirement date, and applies to all earned income whether or not covered by Social Security.

In figuring your total yearly earnings, however, DO NOT COUNT ANY AMOUNTS EARNED BEGINNING WITH THE MONTH YOU ATTAIN FULL RETIREMENT AGE. Count only amounts earned before the you attain full retirement age.

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY BEFORE ANSWERING QUESTION 28.

Benefits may be payable for some months prior to the month in which you file this claim (but not for any month before you reach age 60 (unless you are disabled)) if:

- YOU WILL EARN OVER THE EXEMPT AMOUNT THIS YEAR.

(For the appropriate exempt amount, see "How Work Affects Your Benefits" (Publication No. 05-10069)

If your first month of entitlement is prior to full retirement age, your benefit rate will be reduced. However, if you do not actually receive your full benefit amount for one or more months before full retirement age because benefits are withheld due to your earnings, your benefit will be increased at full retirement age to give credit for this withholding. Thus, your benefit amount at full retirement age will be reduced only if you receive one or more full benefit payments prior to the month you attain full retirement age.