

Application for Mother's or Father's Insurance Benefits*

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 as well.

(Do not write in this space)

*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).

1.	(a) PRINT name of deceased wage earner or self-employed person (<i>herein referred to as the "deceased"</i>).	FIRST NAME, MIDDLE INITIAL, LAST NAME
	(b) Check (X) one for the deceased.	<input type="checkbox"/> Male <input type="checkbox"/> 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.	
3.	Enter your name at birth if different from item 2(a).	
4.	(a) Enter your date of birth.	MONTH, DAY, YEAR
	(b) Enter name of State or foreign country where you were born.	

PLEASE READ CAREFULLY BEFORE ANSWERING ITEM 5

You may receive a mother's or a father's benefit for any month in which you have in your care the deceased's child or dependent grandchild who is entitled to a child's benefit if the child is:

- under age 16,
- or disabled or handicapped (age 16 or over and disability began before age 22).

If you are filing as a surviving divorced mother or father, the child must be your son, daughter, or legally adopted child who is entitled to child's benefits on the deceased's earnings record.

Mother's or father's benefits are not payable if the only child in your care is a child age 16 or over who is not disabled.

5.	Has an unmarried child or dependent grandchild of the deceased, who is under age 16 or disabled, lived with you any time from the month of death through the present month? (This includes adopted child, stepchild, and stepgrandchild.) (If "Yes," enter the information requested below.) <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Name of child	Months and Year child lived with you (<i>If all, write "ALL"</i>)

6.	(a) Are you, or during the past 14 months have you been, unable to work because of illnesses, injuries or conditions?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	(b) Enter the date you became unable to work.	MONTH, DAY, YEAR	
7.	Did you work in the railroad industry for 5 years or more?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8.	(a) Do you have Social Security credits (for example, based on work or residence) under another country's Social Security system?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	(b) If "Yes," list the country(ies).	<i>(If "Yes," answer (b).)</i> <i>(If "No," go on to item 9.)</i>	
9.	Is there a surviving parent (or parents) of the deceased who was receiving support from the deceased at the time of death or at the time the deceased became disabled?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
		<i>(If "Yes," enter the name and address of the parent(s) in "Remarks" on page 5.)</i>	
10.	INFORMATION ON YOUR MARRIAGE(S)		
	(a) Enter information about your marriage to the deceased.		
	Spouse's Name (including maiden name)	When (Month, Day, Year)	Where (Name of City and State)
	How Marriage Ended	When (Month, Day, Year)	Where (Name of City and State)
	Marriage performed by: <input type="checkbox"/> Clergyman or public official <input type="checkbox"/> Other (Explain in "Remarks")	Spouse's date of birth (or age)	Date of death
	(b) If you remarried after the marriage shown in 10. (a), enter information about the last marriage. (If none, write "NONE".) _____		
	Spouse's Name (including maiden name)	When (Month, Day, Year)	Where (Name of City and State)
	How Marriage Ended (enter N/A if marriage has not ended)	When (Month, Day, Year)	Where (Name of City and State)
	Marriage performed by: <input type="checkbox"/> Clergyman or public official <input type="checkbox"/> 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)		

10. (c) If you had 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 you 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, Year)	Where (Name of City and State)
How Marriage Ended (enter N/A if marriage has not ended)	When (Month, Day, Year)	Where (Name of City and State)
Marriage performed by: <input type="checkbox"/> Clergyman or public official <input type="checkbox"/> 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 PAGE 5 FOR INFORMATION ABOUT ANY OTHER MARRIAGES

11. INFORMATION ABOUT THE DECEASED'S MARRIAGE(S)
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, Year)	Where (Name of City and State)
How Marriage Ended	When (Month, Day, Year)	Where (Name of City and State)
Marriage performed by: <input type="checkbox"/> Clergyman or public official <input type="checkbox"/> 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) Enter information about any other marriage the deceased may have had that lasted at least 10 years (see item 10. (c) 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). Do not include the marriage to you.
(If none, write "NONE".) _____

Spouse's Name (including maiden name)	When (Month, Day, Year)	Where (Name of City and State)
How Marriage Ended	When (Month, Day, Year)	Where (Name of City and State)
Marriage performed by: <input type="checkbox"/> Clergyman or public official <input type="checkbox"/> Other (Explain in "Remarks")	Spouse's date of birth (or age)	Date of death
Spouse's Social Security Number (If none or unknown, so indicate)		

USE "REMARKS" SPACE ON PAGE 5 FOR INFORMATION ABOUT ANY OTHER MARRIAGES

IF YOU ARE APPLYING FOR SURVIVING DIVORCED SPOUSE'S BENEFITS, SKIP ITEM 12 AND GO ON TO ITEM 13.

12.	(a) Were you and the deceased living together at the same address when the deceased died?	<input type="checkbox"/> Yes <i>(If "Yes," skip to item 13.)</i>	<input type="checkbox"/> No <i>(If "No," answer (b).)</i>
	(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?	<input type="checkbox"/> You <input type="checkbox"/> Deceased	
	Reason absence began		
	Date last at home		
	Reason you were apart at time of death		
	If separated because of illness, enter nature of illness or disabling condition		

ANSWER ITEM 13 ONLY IF THE DECEASED DIED BEFORE THIS YEAR. OTHERWISE, GO ON TO ITEM 14.

13.	(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 <u>did not earn</u> more than *\$_____ in wages, and <u>did not perform</u> 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."	NONE		ALL	
		JAN	FEB	MAR	APR
		MAY	JUN	JUL	AUG
	*Enter the appropriate monthly limit after reading the instructions, " <u>How Your Earnings Affect Your Benefits</u> ".	SEPT	OCT	NOV	DEC
14.	(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 <u>did not or will not earn</u> more than *\$_____ in wages, and <u>did not or will not perform</u> 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".	NONE		ALL	
		JAN	FEB	MAR	APR
		MAY	JUN	JUL	AUG
	*Enter the appropriate monthly limit after reading the instructions, " <u>How Your Earnings Affect Your Benefits</u> ".	SEPT	OCT	NOV	DEC

ANSWER ITEM 15 ONLY IF YOU ARE NOW IN THE LAST 4 MONTHS OF YOUR TAXABLE YEAR (FOR EXAMPLE, SEPT., OCT., NOV., AND DEC., IF YOUR TAXABLE YEAR IS A CALENDAR YEAR). OTHERWISE, GO ON TO ITEM 16.

15.	(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 <u>do not expect to earn</u> more than *\$_____ in wages, and <u>do not expect to perform</u> 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".	NONE		ALL	
		JAN	FEB	MAR	APR
		MAY	JUN	JUL	AUG
	*Enter the appropriate monthly limit after reading the instructions, " <u>How Your Earnings Affect Your Benefits</u> ".	SEPT	OCT	NOV	DEC
	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			

16.	Check if applicable: <input type="checkbox"/> 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.
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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	<input type="checkbox"/> Checking	<input type="checkbox"/> Enroll in Direct Express
		<input type="checkbox"/> Savings	<input type="checkbox"/> 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 statement about a material fact in this information, or causes someone else to do so, commits a crime and may be subject to a fine or imprisonment.

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
SIGN HERE	AREA CODE

Applicant's Mailing Address (Number and street, Apt No., P.O. Box, or Rural Route) (Enter Residence Address in "Remarks" on page 5, if different.)

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

RECEIPT FOR YOUR CLAIM FOR SOCIAL SECURITY MOTHER'S OR FATHER'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)	SSA OFFICE	DATE CLAIM RECEIVED
	AFTER YOU RECEIVE A NOTICE OF AWARD _____ (AREA CODE)		

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

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.

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.

Always give us your claim number when writing or calling about your claim.

In the meantime, if you change your address, or if

If you have any questions about your claim, we will be glad to help you.

CLAIMAINT	DECEASED'S SURNAME IF DIFFERENT FROM CLAIMANT'S	SOCIAL SECURITY CLAIM NUMBER
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**Privacy Act Statement
Collection and Use of Personal Information**

Sections 202, 205, 223, 226, and 806 of the Social Security Act, as amended, allows 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 a timely and accurate decision on your, or the dependent's entitlement benefits.

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

- To contractors and other Federal Agencies, as necessary, for the purpose of assisting us in the efficient administration of our programs. We will disclose information under this routine use only in situations in which we may enter into a contractual or similar agreement to obtain assistance in accomplishing an SSA function relating to this system of records; and
- To student volunteers, individuals working under a personal services contract, and other workers who technically do not have the status of Federal employees, when they are performing work for the Social Security Administration (SSA), as authorized by law, and they need access to personally identifiable information in SSA records in order to perform their assigned Agency functions.

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, entitled 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 System, as published in the FR on October 31, 2019, at 84 FR 58422; 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 File, as published in the FR on July 25, 2006, at 71 FR 42159. Additional information, and a full listing of all of our SORNs, is 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 control number. We estimate that it will take about 15 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 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. **Send only comments relating to our time estimate or other aspects of this collection to this address, not the completed form.**

CHANGES TO BE REPORTED AND HOW TO REPORT

FAILURE TO REPORT MAY RESULT IN OVERPAYMENTS THAT MUST BE REPAYED, 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.
- Custody Change or Disability Improves - Report if a person for whom you are filing, or who is in your care dies, leaves your care or custody, changes address, or if disabled, the condition improves.
- 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 a court 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.

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. 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:

- Visiting the section "Online Services" at our web site at www.socialsecurity.gov;
- 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.