

**APPLICATION FOR WIFE'S OR HUSBAND'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.

Supplement. If you have already completed an application entitled "APPLICATION FOR RETIREMENT INSURANCE BENEFITS", you need complete only the circled items. All other claimants must complete the entire form.

①	(a) PRINT Name of Wage Earner or Self-Employed Person _____ (Herein referred to as the "Worker")	FIRST NAME, MIDDLE INITIAL, LAST NAME
	(b) Enter Worker's Social Security number _____	- -
2.	Check (X) whether you are _____	<input type="checkbox"/> Male <input type="checkbox"/> Female
③	(a) PRINT your name _____	FIRST NAME, MIDDLE INITIAL, LAST NAME
	(b) Enter your Social Security number _____	- -
4.	If this claim is awarded, do you want a password to use SSA's Internet/phone service? <input type="checkbox"/> Yes <input type="checkbox"/> No	

**Answer question 5 if English is not your preferred language. Otherwise go to item 6.**

5.	Enter the language you prefer to:    Speak _____    Write _____	
6.	(a) Enter your date of birth _____	MONTH, DAY, YEAR
	(b) Enter name of city, State or foreign country where you were born _____	
	(c) Was a public record of your birth made before you were age 5? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
	(d) Was a religious record of your birth made before you were age 5? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
7.	(a) Are you a U.S. citizen? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If "Yes," go to item 8.)</i> <i>(If "No," answer (b).)</i>
	(b) Are you an alien lawfully present in U.S.? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
8.	(a) Enter your full name at birth if different from item 1(a) _____	FIRST NAME, MIDDLE INITIAL, LAST NAME
	(b) Have you used any other name(s)? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If "Yes," answer (c).)</i> <i>(If "No," go to Item 9.)</i>
	(c) Other names(s) used. _____	
9.	(a) Have you used any other Social Security number(s) If "Yes," what number(s) did you use? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

**DO NOT ANSWER QUESTION 10 IF YOU ARE ONE YEAR PAST FULL RETIREMENT AGE OR OLDER.  
GO ON TO QUESTION 11.**

<b>10.</b>	(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 <i>(If "Yes," answer (b).)</i>	<input type="checkbox"/> No <i>(If "No," go to item 11.)</i>
	(b) If "Yes", enter the date you became unable to work. _____ →	MONTH, DAY, YEAR	
<b>11.</b>	(a) Have you (or has someone on your behalf) 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? _____ →	<input type="checkbox"/> Yes <i>(If "Yes," answer (b) and (c).)</i>	<input type="checkbox"/> No <i>(If "No," go to item 12.)</i>
	(b) Enter name of person(s) on whose Social Security record you filed other application. _____ →	FIRST NAME, MIDDLE INITIAL, LAST NAME	
	(c) Enter Social Security number(s) of person named in (b). (If unknown, so indicate) _____ →		

Answer item 12, if you have been in the military service. Otherwise, go to item 13.

<b>12.</b>	(a) Were you in the active military or naval service (including Reserve or National Guard <i>active</i> duty or active duty for training) after September 7, 1939 and before 1968? _____ →	<input type="checkbox"/> Yes <i>(If "Yes," answer (b) and (c).)</i>	<input type="checkbox"/> No <i>(If "No," go to item 13.)</i>
	(b) Enter date(s) of service _____ →	(MONTH, YEAR) (MONTH, YEAR)	
	(c) Have you <u>ever</u> been (or will you be eligible for monthly benefit from a military or civilian Federal agency?) (including Veterans Administration benefits <u>only</u> if you waived Military retirement pay) _____ →	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>13.</b>	Did you, or your spouse, (or prior spouse) work in the railroad industry for 5 years or more? _____ →	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>14.</b>	(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 <i>(If "Yes," answer (b).)</i>	<input type="checkbox"/> No <i>(If "No," go to item 15.)</i>
	(b) List the country(ies): _____ →		

<b>15.</b>	(a) Are you entitled to, or do you expect to be entitled to a pension or annuity (or a lump sum in place of a pension or annuity) based on your own employment and earnings from the Federal government of the United States, or one of its States or local subdivisions? <i>(Social Security benefits are not government pensions.)</i> _____ →	<input type="checkbox"/> Yes <i>(If "Yes," check which of the items in item (b) applies to you.)</i>	<input type="checkbox"/> No <i>(If "No," go on to item 16.)</i>
	(b) Check one box and provide the date in (c)	(c) MONTH YEAR	
	<input type="checkbox"/> I receive a government pension or annuity. <input type="checkbox"/> I receive a lump sum in place of a government pension or annuity. <input type="checkbox"/> I applied for and am awaiting a decision on my pension or lump sum. <input type="checkbox"/> I have not applied for but I expect to begin receiving my pension or annuity.	_____ <i>(If the date is not known, enter "Unknown".)</i>	

I AGREE TO PROMPTLY NOTIFY the Social Security Administration if I begin to receive a government pension or annuity based on my own earnings, from the Federal government or any State (or any political subdivision thereof) or if my present government pension annuity amount changes.

16. Enter below the information requested about each of your marriages. Include information on your marriage to the worker and any other marriages, whether before or after you married the worker.

To whom married		When (Month, day, year)	Where (Name of City and State)
<b>Your current or last marriage</b>	How marriage ended (If still in effect, write "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)		
To whom married		When (Month, day, year)	Where (Name of City and State)
<b>Your previous marriage (If none write "NONE".)</b>	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)		

(Use "Remarks" space on page 5 for information about any other marriages.)

**If you are now under full retirement age or less than one year past full retirement age, answer question 17. If you are more than one year past full retirement age, go to question 18.**

17. Has an unmarried child of the worker (including natural child, adopted child, or stepchild) or a dependent grandchild of the worker (including stepgrandchild) who is under 16 or disabled lived with you during any of the last 13 months (counting the present month)? (If "Yes," enter the information requested below.)

Yes                       No

Name of child	Months child lived with you (if all, write "All")

18. (a) Enter below the names and addresses of all the persons, companies, or government agencies for whom you have worked this year, last year, and the year before last. **IF NONE, WRITE "NONE" BELOW AND GO ON TO THE INSTRUCTIONS FOR ITEM 22.**

NAME AND ADDRESS OF EMPLOYER (If you had more than one employer, please list them in order beginning with your last (most recent) employer).	Work Began		Work Ended (If still working, Show "Not Ended")	
	Month	Year	Month	Year

(If you need more space, use "Remarks")

(b) Are you an officer of a corporation, or are you related to an officer of a corporation? \_\_\_\_\_  Yes                       No

19. (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.

20. (a) How much do you expect your total earnings to be this year? \_\_\_\_\_ ➔ \$ \_\_\_\_\_

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 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 now in the last 4 months of your taxable year (Sept., Oct., Nov., and Dec., if your taxable year is a calendar year).**

21. (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 instructions, "How Your Earnings Affect Your Benefits".

NONE		ALL	
Jan.	Feb.	Mar.	Apr.
May	Jun.	Jul.	Aug.
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 16), enter here the month your fiscal year ends. \_\_\_\_\_ ➔ \_\_\_\_\_  
Month

If you are now under full retirement age and do not have an entitled child in your care, answer item 22.  
 If you are full retirement age or older or you have an entitled child in your care, go to item 23.

**PLEASE READ CAREFULLY THE INFORMATION ON THE BOTTOM of PAGE 7 AND ANSWER ONE OF THE FOLLOWING ITEMS.**

22. (a) I want benefits beginning with the earliest possible month that will be the most advantageous. \_\_\_\_\_ ➔

(b) I am full retirement age (or will be full retirement age within 4 months) and I want benefits beginning with the earliest possible month that will be the most advantageous, providing 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. \_\_\_\_\_ ➔

**MEDICARE INFORMATION**

If this claim is approved and you are still entitled to benefits at age 65, you will automatically have hospital insurance protection under Medicare at age 65. If you are not also eligible for automatic enrollment in the Supplementary Medical Insurance Plan, this application may be used for voluntary enrollment.

**COMPLETE THIS ITEM ONLY IF YOU ARE WITHIN 3 MONTHS OF AGE 65 OR OLDER**

ENROLLMENT IN MEDICARE'S SUPPLEMENTARY MEDICAL INSURANCE PLAN: The medical insurance benefits plan pays for most of the costs of physicians' and surgeons' services, and related medical services which are not covered by the hospital insurance plan. Coverage under this SUPPLEMENTARY MEDICAL INSURANCE PLAN does not apply to most medical expenses incurred outside the United States. Your Social Security district office will be glad to explain the details of the plan and give you a leaflet which explains what services are covered and how payment is made under the plan.

Once you are enrolled in this plan, you will have to pay a monthly premium to cover part of the cost of your medical insurance protection. The Federal Government contributes an equal amount or more toward the cost of your insurance. Premiums will be deducted from any monthly Social Security, railroad retirement, or civil service benefit checks you receive. If you do not receive such benefits, you will be notified about when, where, and how to pay your premiums. If you are eligible for automatic enrollment, you will be automatically enrolled unless you indicate, by checking the "NO" block below, that you do not want to be enrolled.

23. DO YOU WANT TO ENROLL IN THE SUPPLEMENTARY MEDICAL INSURANCE PLAN?  Yes  No

24. If you are within 2 months of age 65 or older, blind or disabled, do you want to file for Supplemental Security Income?  Yes  No

**PLEASE READ THE FOLLOWING INFORMATION CAREFULLY BEFORE SIGNING THIS APPLICATION**

I understand that SSA will use the earnings reported to SSA by my employer(s) and my self-employment tax return (if applicable) as the report of earnings required by law and adjust benefits under the earnings test. I also understand that it is my responsibility to ensure that the information I give SSA concerning my earnings is correct. I also understand that I must furnish additional information as needed when my benefit adjustment is not correct based on the earnings on my record.

BENEFITS MAY END if any of the following events occur. However, there are certain exceptions which are explained in the informational booklet which you will receive. You must report each of these events even if you believe an exception applies. We will advise you whether additional evidence is needed and how your benefits may be affected.

I AGREE TO PROMPTLY NOTIFY the Social Security Administration and to PROMPTLY RETURN ANY BENEFIT CHECK I receive if the check is for a month in or after the month in which:

- The worker DIES. (You may be entitled to survivor's benefits.)
- I am DIVORCED or my marriage is ANNULLED.
- I MARRY. (If I am entitled as a divorced spouse.)
- I NO LONGER HAVE IN MY CARE the worker's child or dependent grandchild under age 16 or disabled who is entitled to benefits.
- I am confined to jail, prison, penal institution or correctional facility or conviction of a crime or confined to a public institution by court order in connection with a crime.

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

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**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.
- ▶ 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 \$ \_\_\_\_\_ . (Year)

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 are confined 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 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 begin to receive a government pension or annuity (from the Federal government or any State or any political subdivision thereof) or present payment changes.

**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; or
- Calling, visiting or writing your local Social Security office at the phone number and address above.

For general information about Social Security, visit our web site at [www.socialsecurity.gov](http://www.socialsecurity.gov).

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.

**Under a special rule known as the Monthly Earnings Test, you can get a full benefit for any month in which you do not earn wages over the monthly limit and do not perform substantial services in self-employment regardless of how much you earn in the year. For retirement age beneficiaries this special rule can be used only for one taxable year which will usually be the year of retirement. For younger beneficiaries such as young wives and husbands (entitled only by reason of child-in-care), this special rule can be used for two taxable years. The first taxable year in which the monthly earnings test may be used is usually the first year they are entitled to benefits. The second taxable year in which the monthly earnings test can be used is always the year in which their entitlement to benefits stops. In all other years, the total amount of benefits payable will be based solely on your total yearly earnings without regard to monthly earnings or services rendered in self-employment.**

**PLEASE READ THE FOLLOWING INFORMATION CAREFULLY  
BEFORE YOU ANSWER QUESTION 22.**

Benefits may be payable for some months prior to the month in which you file this claim (but not for any month before the first month you will be age 62 for the entire month) if:

You will earn over the exempt amount this year. For the appropriate exempt amount, see "How Your Earnings Affect Your Benefits."

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.

**RECEIPT FOR YOUR CLAIM FOR SOCIAL SECURITY WIFE'S OR HUSBAND'S INSURANCE BENEFITS**

TELEPHONE NUMBER(S) TO CALL IF YOU HAVE A QUESTION OR SOME- THING TO REPORT	<b>BEFORE YOU RECEIVE A NOTICE OF AWARD</b>  (     )     -	SSA OFFICE	DATE CLAIM RECEIVED
	<b>AFTER YOU RECEIVE A NOTICE OF AWARD</b>  (     )     -		

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 to the telephone number shown above. The changes to be reported are listed on pages 5 and 7. 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.

<b>CLAIMANT</b>	<b>WORKER'S SURNAME IF DIFFERENT FROM CLAIMANT'S</b>	<b>SOCIAL SECURITY NUMBER</b>

**PAPERWORK REDUCTION ACT**

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 20 minutes to read the instructions, gather the facts, and answer the questions. **SEND THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE.** The office is listed under U. S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213. *You may send comments on our time estimate above to: SSA, 1338 Annex Building, Baltimore, MD 21235-0001. **Send only comments relating to our time estimate to this address, not the completed form.***

**Collection and Use of Information From Your Application—Privacy Act/Paperwork Act Notice**

The Social Security Administration is authorized to collect the information on this form under sections 202(b), 202(c), 205(a), and 1872 of the Social Security Act, as amended 42 U.S.C. 402 (b), 402(c), 405(a), and 1395(ii). While it is voluntary, except in the circumstances explained below, for you to furnish the information on this form to Social Security, no benefits may be paid unless an application has been received by a Social Security office. Your response is mandatory where the refusal to disclose certain information affecting your right to payment would reflect a fraudulent intent to secure benefits not authorized by the Social Security Act. The information on this form is needed to enable Social Security to determine if you and your dependents are entitled to insurance coverage and/or monthly benefits. Failure to provide all or part of this information could prevent an accurate and timely decision on your claim or your dependent's claim, and could result in the loss of some benefits or insurance coverage. Although the information you furnish on this form is almost never used for any other purpose than stated in the foregoing, there is a possibility that for the administration of the Social Security programs or for the administration of programs requiring coordination with the Social Security Administration, information may be disclosed to another person or to another governmental agency as follows:

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 General Accounting Office and the Veterans Administration); and 3. to facilitate statistical research and audit activities necessary to assure the integrity and improvement of the Social Security programs (e.g., to the Bureau of the Census and private concerns under contract to Social Security.) We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it.

Explanations about these and other reasons why information you provide us may be used or given out are available in Social Security offices. If you want to learn more about this, contact any Social Security office.