**ATTENTION:**

**Please do not complete this form. This form is only used to give you an idea of the questions we will ask when you apply. It will help you prepare for the interview.**

SOCIAL SECURITY ADMINISTRATION

☐ TEL

TOE 120/145/155

Form Approved
OMB No. 0960-0007

(Do not write in this space)

## APPLICATION FOR RETIREMENT INSURANCE BENEFITS

I apply for all insurance benefits for which I am eligible under Title 11 (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 WIFE'S OR HUSBANDS'S INSURANCE BENEFITS", you need complete only the circled items. All other claimants must complete the entire form.

| | | |
|---|---|---|
| 1. (a) | PRINT your name → | FIRST NAME, MIDDLE INITIAL, LAST NAME |
| | (b) Enter your name at birth if different from item (a) → | FIRST NAME, MIDDLE INITIAL, LAST NAME |
| | (c) Check (X) whether you are → | ☐ Male ☐ Female |
| 2. | Enter your Social Security Number → | ___ ___ ___ / ___ ___ / ___ ___ ___ ___ |
| 3. | (a) Enter your 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 4.

| | | |
|---|---|---|
| | (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 |
| 4. | (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? → | ☐ Yes *(If "Yes," answer (b) and (c).)* ☐ No *(If "No," go on to item 5.)* |
| | (b) Enter name of person on whose Social Security record you filed other application. → | (First name, middle initial last name) |
| | (c) Enter Social Security Number of person named in (b). *(If unknown, so indicate)* → | ___ ___ ___ / ___ ___ / ___ ___ ___ ___ |

Do not answer 5 if you are age 66 or older. Go on to question 6.

| | | |
|---|---|---|
| 5. | (a) Are you, or during the past 14 months have you been, unable to work because of illnesses, injuries or conditions? → | ☐ Yes ☐ No |
| | (b) If "Yes," enter the date you became unable to work. → | MONTH, DAY, YEAR |
| 6. | (a) 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 *(If "Yes," answer (b) and (c).)* ☐ No *(If "No," go on to Item 7.)* |
| | (b) Enter dates of service. → | *From: (Month, year)* / *To: (Month, year)* |
| | (c) Have you <u>ever</u> been (or will you be) eligible for a monthly benefit from a military or civilian Federal agency? (include Veterans Administration benefits <u>only</u> if you waived military retirement pay) → | ☐ Yes ☐ No |
| 7. | Have you or your spouse worked in the railroad industry for 7 years or more? → | ☐ Yes ☐ No |

| | | |
|---|---|---|
| 8. | (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 9.)* |
| | (b) If "Yes," list the country(ies). → | |
| 9. | Have you ever been married? → | ☐ Yes *(If "Yes," answer item 10.)* ☐ No *(If "No," go to item 12.)* |

10. (a) Give the following information about your current marriage. If not currently married, show your last marriage below.

| | | | |
|---|---|---|---|
| To whom married | | When *(Month, day, year)* | Where *(Name of City and State)* |
| Your current or last marriage | 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 ☐ 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) Give the following information about each of your previous marriages. **(IF NONE, WRITE "NONE")**

| | | | |
|---|---|---|---|
| To whom married | | When *(Month, day, year)* | Where *(Name of City and State)* |
| Your previous marriage (Use a separate statement for information about any other marriages.) | How marriage ended | When *(Month, day, 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) | ___ ___ ___ / ___ ___ / ___ ___ ___ ___ | |

11. If you are currently married, answer this question, **only** if your spouse is within 3 months of age 62 or older; or has a child-in-care who is eligible on your earnings record
Do you wish this application to protect your spouse's right to Social Security benefits? ☐ Yes ☐ No

12. List below FULL NAME OF ALL your children (including natural children adopted children, and stepchildren) or dependent grandchildren (including stepgrandchildren) who are now or were in the past 6 months UNMARRIED and:
- UNDER AGE 18
- AGE 18 TO 19 AND ATTENDING SECONDARY SCHOOL
- DISABLED OR HANDICAPPED (age 18 or over and disability began before age 22)

Also list any student who is between the ages of 18 to 23 if such student was both: 1. Previously entitled to Social Security benefits on any Social Security record for August 1981, and 2. Was also in full-time attendance at a post-secondary school prior to May 1982.

**(IF THERE ARE NO SUCH CHILDREN, WRITE "NONE" BELOW AND GO ON TO ITEM 13.)**

| | |
|---|---|
| | |

| | | |
|---|---|---|
| 13. | (a) Did you have wages or self-employment income covered under Social Security in all years from 1 978 through last year? | ☐ Yes (If "Yes," skip to item 14 ) ☐ No (If "No," answer (b).) |
| | (b) List the years from 1 978 through last year in which you did not have wages or self-employment income covered under Social Security. | |

14. 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 ITEM 16.**

| (a) 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 |
| | | | | |
| | | | | |

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

15. May we ask your employers for wage information needed to process your claim? → ☐ Yes ☐ No

16. THIS ITEM MUST BE COMPLETED, EVEN IF YOU ARE AN EMPLOYEE
(a) Were you self-employed this year and/or last year? → ☐ Yes (If "Yes," answer (b).) ☐ No (If "No," skip to item 17.)

| (b) Check the year or years in which you were self-employed | In what kind of trade or business were you self-employed? (For example, storekeeper, farmer, physician) | Were your net earnings from your trade or business $400 or more? *(Check "Yes" or "No")* |
|---|---|---|
| ☐ This year | | |
| ☐ Last year | | ☐ Yes ☐ No |
| ☐ Year before last | | ☐ Yes ☐ No |

17. (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. |

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

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

19. **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).**

(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. |

"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."

20. 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 AGE 65 AND 6 MONTHS, OR OLDER, DO NOT ANSWER ITEM 21. GO ON TO ITEM 22.

**PLEASE READ CAREFULLY THE INFORMATION ON THE OPPOSITE PAGE AND ANSWER ONE OF THE FOLLOWING ITEMS.** →

21. (a) I want benefits beginning with the earliest possible month that will be the most advantageous. → ☐

(b) I am age 65 (or will be age 65 within 4 months) and I want benefits beginning with the earliest possible month that will be the most advantageous providing there is not permanent reduction in my ongoing monthly benefit. → ☐

(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. → ☐

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.

22. DO YOU WANT TO ENROLL IN THE MEDICARE SUPPLEMENTARY MEDICAL INSURANCE PLAN? → ☐ Yes ☐ No

Answer question 23 ONLY if you were born January 2, 1924, or later. Otherwise, go on to question 24.

| | | | |
|---|---|---|---|
| 23. | (a) Are you entitled to, or do you expect to become entitled to, a pension or annuity based on your work after 1956 not covered by Social Security? | ☐ Yes (If "Yes," answer (b) and (c).) ☐ No (If "No," go on to item 24.) | |
| | (b) ☐ I became entitled, or expect to become entitled, beginning → | MONTH | YEAR |
| | ☐ I became eligible, or expect to become eligible, beginning → | MONTH | YEAR |

I agree to notify the Social Security Administration if I become entitled to a pension or annuity based on my employment after 1956 not covered by Social Security, or if such pension or annuity stops.

24. Check if applicable:
☐ I am not submitting evidence of earnings that are not yet on my 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.

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

**I know that anyone who makes or causes to be made a false statement or representation of material fact in an application or for use in determining a right to payment under the Social Security Act commits a crime punishable under Federal law by fine, imprisonment or both. I affirm that all information I have given in this document is true.**

## 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. 0. 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)* |

## 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.
- 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 above work pattern changes)
- 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.
- You become entitled to a pension or annuity based on your employment after 1956 not covered by Social Security, or if such pension or annuity stops.
- **Your stepchild is entitled to benefits on your record and you and the stepchild's parent divorce. Stepchild benefits are not payable beginning with the month after the month the divorce becomes final.**
- 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.
- Change of Marital Status - Marriage, divorce, annulment of marriage.

**HOW TO REPORT**

You can make your reports by telephone, mail, or in person, whichever you prefer.

WHEN A CHANGE OCCURS AFTER YOU RECEIVE A NOTICE OF AWARD, YOU SHOULD REPORT BY CALLING THE APPROPRIATE TELEPHONE NUMBER SHOWN NEAR THE TOP OF PAGE 6.

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.

## PLEASE READ THE FOLLOWING INFORMATION CAREFULLY BEFORE YOU ANSWER QUESTION 21.

If you are under age 65, retirement benefits cannot be payable to you for any month before the month in which you file this claim.

If you are over age 65, retirement benefits may be payable to you for some months before the month in which you file this claim (but not before the month you attain age 65).

If your first month of entitlement is prior to age 65, your benefit rate will be reduced. However, if you do not actually receive your full benefit amount for one or more months before age 65 because benefits are withheld due to your earnings your benefit will be increased at age 65 to give credit for this withholding. Thus, your benefit amount at age 65 will be reduced only if you receive one or more full benefit payments prior to the month you are 65.

## RECEIPT FOR YOUR CLAIM FOR SOCIAL SECURITY RETIREMENT INSURANCE 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 meantine, 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 5.

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 |
|---|---|
| | |

### Collection and Use of Information From Your Application- Privacy Act Notice/Paperwork Act Notice

The Social Security Administration is authorized to collect the information on this form under sections 202(a), 205(a) and 1872 of the Social Security Act, as amended (42 U S C 402(a), 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)

The information you provide may also be used without your consent in automated matching programs. These matching programs are computer comparisons of Social Security Administration records with records kept by other Federal agencies or State and local government agencies. Information from these matching programs can be used to establish or verify a person's eligibility for Federally funded or administered benefit programs and for repayment of payments or delinquent debts under these programs.

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.

### PAPERWORK REDUCTION ACT NOTICE

**The Paperwork Reduction Act of 1995** requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1 995. We may not conduct or sponsor and you are not required to respond to, a collection of information unless it displays a valid OMB control number. We estimate that it will take you about 10 1/2 minutes to complete this form. This includes the time it will take to read the instructions, gather the necessary facts and fill out the form.