SOCIAL SECURITY ADMINISTRATION ☐ TEL Form Approved OMB No. 0960-0060 TOE 120/145

(Do not write in this space)

APPLICATION FOR DISABILITY INSURANCE BENEFITS

I apply for a period of disability and/or all insurance benefits for which I am eligible under title II and part A of title XVIII of the Social Security Act, as presently amended.

PART I—INFORMATION ABOUT THE DISABLED WORKER

1. (a) PRINT your name → FIRST NAME, MIDDLE INITIAL, LAST NAME

(b) Enter your name at birth if different from item (a) →

(c) Check (√) 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) What are the illnesses, injuries, or conditions that limit your ability to work? (Give a brief description.)

(b) Are your illnesses, injuries or conditions related to your work in anyway? → ☐ Yes ☐ No

5. (a) When did you become unable to work because of your illnesses, injuries or conditions? → MONTH, DAY, YEAR

(b) Are you still unable to work? → ☐ Yes ☐ No

(c) If you are no longer unable to work because of your illnesses, injuries or conditions, enter the date you became able to work. → MONTH, DAY, YEAR

6. (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 ☐ Unknown (If "No," or "Unknown" go on to item 7.)

(b) Enter name of person on whose Social Security record you filed other application. →

(c) Enter Social Security Number of person named in (b). *If unknown, check this block.* ☐ → __ __ __ / __ __ / __ __ __ __

7. (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 8.)

(b) Enter dates of service → FROM: (month, year) TO: (month, year)

(c) Have you *ever* been (or will you be) eligible for a monthly benefit from a military or civilian Federal agency? (include Veterans Administration benefits *only* if you waived military retirement pay) → ☐ Yes ☐ No

8. (a) Have you filed (or do your intend to file) for any other public disability benefits? (Include workers' compensation and Black Lung benefits) → ☐ Yes (If "Yes," answer (b).) ☐ No (If "No," go on to item 9.)

(b) The other public disability benefit(s) you have filed (or intend to file) for is (Check as many as apply):

☐ Veterans Administration Benefits ☐ Welfare
☐ Supplemental Security Income ☐ Other (If "Other," complete a Workers' Compensation/Public Disability Benefit Questionnaire)

9. (a) Do you have social security credits (for example, based on work or residence) under another country's Social Security System? (If "Yes," answer (b).) (If "No," go on to item 10.) → ☐ Yes ☐ No

(b) List the country(ies): →

10. (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 11.)

	MONTH	YEAR
(b) ☐ I became entitled, or expect to become entitled, beginning		
(c) ☐ I became eligible, or expect to become eligible, beginning		

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 of annuity stops.

11. (a) Did you have wages or self-employment income covered under Social Security in all years from 1978 through last year? ☐ Yes (If "Yes," skip to item 12.) ☐ No (If "No," answer (b).)

(b) List the years from 1978 through last year in which you did not have wages or self-employment income covered under Social Security.

12. Enter below the names and addresses of all the persons, companies, or Government agencies for whom you have worked this year and last year. IF NONE, WRITE "NONE" BELOW AND GO ON TO ITEM 14.

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" space on page 4.)				

13. May the Social Security Administration or the State agency reviewing your case ask your employers for information needed to process your claim? → ☐ Yes ☐ No

14. THIS ITEM MUST BE COMPLETED, EVEN IF YOU WERE AN EMPLOYEE.

(a) Were you self-employed this year and last year? (If "Yes," answer (b).) (If "No," go on to item 15.) → ☐ Yes ☐ No

(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

15. (a) How much were your total earnings last year? (Count both wages and self-employment income. If none, write "None.") → Amount $ _____

(b) How much have you earned so far this year? (If none, write "None.") → Amount $ _____

(c) Did you receive any money from an employer(s) on or after the date in item 5(a) when you became unable to work because of your illnesses, injuries, or conditions? (If "Yes", give the amounts and explain in "Remarks" on page 4.) → ☐ Yes ☐ No Amount $ _____

(d) Do you expect to receive any additional money from an employer such as sick pay, vacation pay, other special pay? (If "Yes," please give amounts and explain in "Remarks" on page 4.) → ☐ Yes ☐ No Amount $ _____

PART II—INFORMATION ABOUT THE DISABLED WORKER AND SPOUSE

16. Have you ever been married? → ☐ Yes ☐ No
(If "Yes," answer item 17.) (If "No," go on to item 18.)

17. (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	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) ___ ___ ___ / ___ ___ / ___ ___ ___ ___		

(Use a separate statement for information about any other marriages.)

18. Have you or your spouse worked in the railroad industry for 7 years or more? → ☐ Yes ☐ No

PART III—INFORMATION ABOUT THE DEPENDENTS OF THE DISABLED WORKER

19. If your claim for disability benefits is approved, your children (including natural children, adopted children, and stepchildren) or dependent grandchildren (including stepgrandchildren) may be eligible for benefits based on your earnings record.

List below: FULL NAME OF ALL such children who are now or were in the past 12 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)

(IF THERE ARE NO SUCH CHILDREN, WRITE "NONE" BELOW AND GO ON TO ITEM 20.)

20. Do you have a dependent parent who was receiving at least one-half support from you when you became unable to work because of your disability? (if "Yes," enter name and address in "Remarks" on page 4.) ☐ Yes ☐ No

IMPORTANT INFORMATION ABOUT DISABILITY INSURANCE BENEFITS — PLEASE READ CAREFULLY

I. SUBMITTING MEDICAL EVIDENCE: I understand that as a claimant for disability benefits, I am responsible for providing medical evidence showing the nature and extent of my disability. I may be asked either to submit the evidence myself or to assist the Social Security Administration in obtaining the evidence. If such evidence is not sufficient to arrive at a determination, I may be requested by the State Disability Determination Service to have an independent examination at the expense of the Social Security Administration.

II. RELEASE OF INFORMATION: I authorize any physician, hospital, agency or other organization to disclose to the Social Security Administration, or to the State Agency that may review my claim or continuing disability, any medical record or other information about my disability.

I also authorize the Social Security Administration to release medical information from my records, only as necessary to process my claim, as follows:

- Copies of medical information may be provided to a physician or medical institution prior to my appearance for an independent medical examination if an examination is necessary.
- Results of any such independent examination may be provided to my personal physician.
- Information may be furnished to any contractor for transcription, typing, record copying, or other related clerical or administrative service performed for the State Disability Determination Service.
- The State Vocational Rehabilitation Agency may review any evidence necessary for determining my eligibility for rehabilitative services.

THIS MUST BE ANSWERED ➧ 21. DO YOU UNDERSTAND AND AGREE WITH THE AUTHORIZATIONS GIVEN ABOVE?

☐ Yes ☐ No (If "No," explain why in "Remarks.")

22. Check if applicable:

( ) I am not submitting evidence of ( ) my ( ) the deceased's earnings that are not yet on ( ) my ( ) his/her earnings record. I understand that these earnings will be included automatically within 24 months, and any increase in benefits will be paid with full retroactivity.

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

III. REPORTING RESPONSIBILITIES: I agree to promptly notify Social Security if:

- My MEDICAL CONDITION IMPROVES so that I would be able to work, even though I have not yet returned to work.
- I GO TO WORK whether as an employee or a self-employed person.
- I apply for or begin to receive a workers' compensation (including black lung benefits) or another public disability benefit, or the amount that I am receiving changes or stops, or I receive a lump-sum settlement.
- I am confined to jail, prison, a penal institution or correctional facility for conviction or a crime or I am confined to a public institution by court order in connection with a crime.

The above events may affect my eligibility or disability benefits as provided in the Social Security Act, as amended.

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. (include the area code)

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

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

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

Witnesses are required ONLY if this application has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the applicant must sign below, giving their full addresses. Also, print the applicant's name in 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)*

FOR YOUR INFORMATION

An agency in your State that works with us in administering the Social Security disability program is responsible for making the disability decision on your claim. In some cases, it is necessary for them to get additional information about your condition or to arrange for you to have a medical examination at Government expense.

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(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.

PAPERWORK REDUCTION ACT NOTICE AND TIME IT TAKES STATEMENT:

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 1995. 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 20 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.

RECEIPT FOR YOUR CLAIM FOR SOCIAL SECURITY DISABILITY INSURANCE BENEFITS

PERSON TO CONTACT ABOUT YOUR CLAIM	SSA OFFICE	DATE CLAIM RECEIVED
TELEPHONE NUMBER (INCLUDE AREA CODE)		

Your application for Social Security disability 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 below.

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

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

CLAIMANT	SOCIAL SECURITY CLAIM NUMBER

CHANGES TO BE REPORTED AND HOW TO REPORT

FAILURE TO REPORT MAY RESULT IN OVERPAYMENTS THAT MUST BE REPAID

- 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.
- 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 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.
- Change of Marital Status—Marriage, divorce, annulment of marriage.
- You return to work (as an employee or self-employed) regardless of amount of earnings.
- Your condition improves.
- If you apply for or begin to receive workers' compensation (including black lung benefits) or another public disability benefit, or the amount of your present workers' compensation or public disability benefit changes or stops, or you receive a lump-sum settlement.

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 changes occur, the change(s) should be reported by calling:

_____

(Telephone Number—Include Area Code)

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