

APPLICATION FOR SOCIAL SECURITY BENEFITS CHILD'S INSURANCE BENEFITS

(Do not write in this space)

With this application, you are applying on behalf of the child or children listed in item 3 below for all insurance benefits for which they may be eligible under Title II (Federal Old-Age, Survivors and Disability Insurance) of the Social Security Act as presently amended. If you are applying on your own behalf, answer the questions on this form with respect to yourself.

If you are applying for benefits based on the earnings record of a Deceased Worker, 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).

☐ Life
Claim

☐ Death
Claim

1.	(a) PRINT name of Wage Earner or Self-Employed person (herein referred to as the "Worker").	FIRST NAME, MIDDLE INITIAL, LAST NAME
	(b) PRINT Worker's Social Security number.	
2.	(a) PRINT your name (unless you are the Worker).	FIRST NAME, MIDDLE INITIAL, LAST NAME
	(b) PRINT your Social Security number.	

PART 1 - INFORMATION ABOUT THE WORKER'S CHILDREN

3. The Worker's children (including natural children, adopted children, and stepchildren) or dependent grandchildren (including step grandchildren) may be eligible for benefits based on the earnings record of the Worker. For a living Worker, the information below applies to this month or to any of the past 12 months. For a deceased Worker, the information below applies to the date of death or for any period since the Worker's death.

List below all children who are: • Under age 18 • Age 18 to 19 and attending elementary or secondary school (grade 12 or lower) full-time • Age 18 or older with a disability that began before age 22	Date of Birth (MM/DD/YYYY)	Check (X) if Child 17.5 or Older is:		Check (X) the Column That Shows Child's Relationship to Worker						CHILD'S SOCIAL SECURITY NUMBER
		Student	Disabled	Natural	Adopted	Stepchild	Dependent Grandchild	Other		
FULL NAME OF CHILD										
		☐	☐	☐	☐	☐	☐	☐		
		☐	☐	☐	☐	☐	☐	☐		
		☐	☐	☐	☐	☐	☐	☐		
		☐	☐	☐	☐	☐	☐	☐		
		☐	☐	☐	☐	☐	☐	☐		
		☐	☐	☐	☐	☐	☐	☐		

If you do not wish to be payee for any child or dependent grandchild named above, list the child's name and address in "Remarks" on page 5. You may apply for a child even though you do not wish to be payee for the child's benefits.

4.	If any children in item 3 are stepchildren of the Worker, enter the date the Worker married the natural parent.	MM/DD/YYYY
5.	(a) Is there a legal representative (guardian, conservator, curator, etc.) for any of the children in item 3?	☐ Yes (If "Yes," complete (b) and (c).) ☐ No (If "No," go on to item 6.)

5.	(b) Write the following information about the legal representative(s):	NAME (First name, middle initial, last name) ADDRESS	TELEPHONE NUMBER (INCLUDE AREA CODE)																	
(c) Briefly explain the circumstances which led the court to appoint a legal representative.																				
6.	Are you the natural or adoptive parent of the person(s) for whom you are filing? ☐ Yes ☐ No																			
7.	Have any children in item 3 ever been adopted by someone other than the Worker? ☐ Yes ☐ No (If "Yes," enter the following information):																			
<table border="1"> <thead> <tr> <th data-bbox="105 672 673 703">Name of Child</th> <th data-bbox="673 672 893 703">Date of Adoption</th> <th data-bbox="893 672 1578 703">Name of Person Adopting</th> </tr> </thead> <tbody> <tr> <td data-bbox="105 703 673 798"></td> <td data-bbox="673 703 893 798"></td> <td data-bbox="893 703 1578 798"></td> </tr> <tr> <td data-bbox="105 798 673 892"></td> <td data-bbox="673 798 893 892"></td> <td data-bbox="893 798 1578 892"></td> </tr> </tbody> </table>				Name of Child	Date of Adoption	Name of Person Adopting														
Name of Child	Date of Adoption	Name of Person Adopting																		
8.	Are all the children in item 3 now living in the same household with you? (If "No," enter the following information about each child not living with you. If uncertain as to the whereabouts of any of these children, explain in "Remarks".)		☐ Yes ☐ No																	
<table border="1"> <thead> <tr> <th data-bbox="105 1039 511 1155" rowspan="2">Name of Child Not Living With You</th> <th colspan="2" data-bbox="511 1039 1578 1092">Person With Whom Child Now Lives</th> </tr> <tr> <th data-bbox="511 1092 1250 1155">Name and Address</th> <th data-bbox="1250 1092 1578 1155">Relationship to Child</th> </tr> </thead> <tbody> <tr> <td data-bbox="105 1155 511 1249"></td> <td data-bbox="511 1155 1250 1249"></td> <td data-bbox="1250 1155 1578 1249"></td> </tr> <tr> <td data-bbox="105 1249 511 1344"></td> <td data-bbox="511 1249 1250 1344"></td> <td data-bbox="1250 1249 1578 1344"></td> </tr> <tr> <td data-bbox="105 1344 511 1438"></td> <td data-bbox="511 1344 1250 1438"></td> <td data-bbox="1250 1344 1578 1438"></td> </tr> <tr> <td data-bbox="105 1438 511 1543"></td> <td data-bbox="511 1438 1250 1543"></td> <td data-bbox="1250 1438 1578 1543"></td> </tr> </tbody> </table>				Name of Child Not Living With You	Person With Whom Child Now Lives		Name and Address	Relationship to Child												
Name of Child Not Living With You	Person With Whom Child Now Lives																			
	Name and Address	Relationship to Child																		
9.	Has any child in item 3 ever been married? (If "Yes," enter the information requested below.)		☐ Yes ☐ No																	
Name of Child		Date of Marriage (MM/DD/YYYY)																		
How Marriage Ended (If still married, write "not ended").		Date Marriage Ended (MM/DD/YYYY)																		

If you are applying ONLY for a child age 18 or over who is disabled, omit items 10 through 13.
In all other cases, answer items 10 through 13.

EARNINGS INFORMATION FOR LAST YEAR (Do not complete if the Worker died this year)

10.	(a) Did any child in item 3 earn more than the exempt amount last year? (If "Yes," answer (b.). If "No," go on to item 11.)	☐ Yes ☐ No	
	(b) NAME OF CHILD WHO EARNED OVER THE EXEMPT AMOUNT LAST YEAR	TOTAL EARNINGS OF CHILD	LIST EACH MONTH THAT CHILD DID NOT EARN MORE THAN \$ _____ IN WAGES AND DID NOT PERFORM SUBSTANTIAL SERVICES IN SELF-EMPLOYMENT
		\$	
		\$	
		\$	

EARNINGS INFORMATION FOR THIS YEAR

11.	(a) Do you expect the total earnings of any child in item 3 to be more than the exempt amount this year? (Count all earnings beginning with the first of this year and all anticipated earnings through the end of this year.) (If "Yes," answer (b). If "No," go on to item 12.)	☐ Yes ☐ No	
	(b) NAME OF CHILD WHO EXPECTS TO EARN OVER THE EXEMPT AMOUNT THIS YEAR	EXPECTED EARNINGS OF CHILD	LIST EACH MONTH (INCLUDING THE PRESENT MONTH) THAT CHILD DID NOT OR WILL NOT EARN MORE THAN \$ _____ IN WAGES AND DID NOT OR WILL NOT PERFORM SUBSTANTIAL SERVICES IN SELF-EMPLOYMENT
		\$	
		\$	
		\$	

Complete item 12 ONLY if any child is now in the last 4 months of the child's taxable year (Sept., Oct., Nov., and Dec., if the taxable year is a calendar year).

EARNINGS INFORMATION FOR NEXT YEAR

12.	(a) Do you expect the total earnings of any child in item 3 to be more than the exempt amount next year? (If "Yes," answer (b.). If "No," go on to item 13.)	☐ Yes ☐ No	
	(b) NAME OF CHILD WHO EXPECTS TO EARN OVER THE EXEMPT AMOUNT NEXT YEAR	EXPECTED EARNINGS OF CHILD	LIST EACH MONTH THAT CHILD WILL NOT EARN MORE THAN \$ _____ IN WAGES AND WILL NOT PERFORM SUBSTANTIAL SERVICES IN SELF-EMPLOYMENT
		\$	
		\$	
		\$	

13.	If any of the children for whom you are filing uses a fiscal year (one that does not end on December 31), print here the name of the child and the month the fiscal year ends.	Name of child and month fiscal year ends
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Complete items 14 and 15 ONLY if the Worker is living. Otherwise, go on to item 16.

14.	If any children in item 3 are children adopted by the Worker, print below the name of each such child and the date of adoption by the Worker.	
	NAME OF ADOPTED CHILD	DATE OF ADOPTION

15.	Have all of the children in item 3 lived with the Worker during each of the last 13 months (counting the present month)? (If "No," enter the information requested below.)		☐ Yes ☐ No	
	NAME OF CHILD WHO DID NOT LIVE WITH THE WORKER IN EACH OF THE LAST 13 MONTHS	LIST EACH MONTH IN WHICH THIS CHILD DID NOT LIVE WITH THE WORKER	PERSON WITH WHOM CHILD LIVED	
			NAME AND ADDRESS	RELATIONSHIP TO CHILD
16.	If any of the children in item 3 are within 2 months of age 65 or older, blind or disabled, do you want to file on their behalf for Supplemental Security Income?		☐ Yes ☐ No	

PART 2 - INFORMATION ABOUT THE DECEASED. Complete items 17 through 24 only if the Worker is deceased.

17.	(a) Print date of birth of Worker	MM/DD/YYYY
	(b) Print Worker's name at birth if different from item 1 (a)	
18.	(a) Print date of death	MM/DD/YYYY
	(b) Print place of death	CITY AND STATE
19.	Print the name of the state or foreign country where the Worker had a fixed, permanent home at the time of death.	STATE OR FOREIGN COUNTRY
20.	Did the Worker work in the railroad industry for 5 years or more?	☐ Yes ☐ No
21.	(a) Did the worker 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 22.)
	(b) List the country(ies).	
22.	(a) Did the worker have wages or self-employment income covered under Social Security in all years from 1978 through last year?	☐ Yes (If "Yes", skip to item 23.) ☐ No (If "No," answer (b).)
	(b) List the years from 1978 through last year in which the worker did not have wages or self-employment income covered under Social Security.	

Answer item 23 ONLY if death occurred within the last 2 years.

23.	(a) How much did the Worker earn from employment and self-employment during the year of death?	AMOUNT \$
	(b) How much did the Worker earn the year before death?	AMOUNT \$

24.	Check if applicable: ☐ I am not submitting evidence of the deceased's earnings that are not yet on their 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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Answer item 25 ONLY if the Worker died prior to age 66 and within the past 4 months.

25.	(a) Was the Worker unable to work because of a illnesses, injuries or conditions at the time of death?	☐ Yes (If "Yes," answer (b).)	☐ No
	(b) Enter the date the Worker first became unable to work	MM/DD/YYYY	
26.	Were all the children in item 3 living with the Worker at the time of death? (If "No," enter the following information)		☐ Yes ☐ No
	NAME OF CHILD NOT LIVING WITH THE WORKER	PERSON WITH WHOM CHILD WAS LIVING	
		NAME AND ADDRESS	RELATIONSHIP TO CHILD

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

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 (MM/DD/YYYY)
SIGNATURE (First Name, Middle Initial, Last Name) (Write in ink)	Telephone Number(s) at which you may be contacted during the day

Direct Deposit Payment Information (Financial Institution)			
Routing Transit Number	Account Number	☐ Checking	☐ Enroll in Direct Express
		☐ Savings	☐ 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
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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)

Privacy Act Statement Collection and Use of Personal Information

Section 202(d) 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 an accurate and timely decision on any claim filed.

We will use the information to determine eligibility for monthly benefits or insurance coverage and to authorize payments to the child(ren) of retired, disabled, or deceased workers. We may also share your information for the following purposes, called routine uses:

- To Federal, State, or local agencies for administering cash or non-cash income or health maintenance programs; and
- To a contractor or another Federal agency, as necessary for the purpose of assisting the Social Security Administration in the efficient administration of its programs.

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 Notice (SORN) 60-0089, entitled Claims Folders System, as published in the Federal Register (FR) on April 1, 2003, at 68 FR 15784. 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 12 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 on our time estimate above to: SSA, 6401 Security Blvd, Baltimore, MD 21235-6401. **Send only comments relating to our time estimate to this address, not the completed form.***

RECEIPT FOR YOUR CLAIM FOR SOCIAL SECURITY CHILD'S 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 on behalf of the child(ren) named below has been received. You will be notified by mail as soon as a decision is made on your claim.

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 or any child(ren) changes 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 9.

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

WORKER'S NAME (If surname differs from name of claimant(s).)

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 or any child changes 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.
- Any child's citizenship or immigration status changes.
- Any beneficiary goes 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 _____ expected total earnings
(Name of Child)
for _____ to be \$ _____.
(Year)
_____ ☐ (is) ☐ (is not) earning
(Name of Child)
wages of more than \$ _____ a month.
_____ ☐ (is) ☐ (is not) self-employed
(Name of Child)
and rendering substantial services in a trade or business.
(Report AT ONCE if this work pattern changes.)
- Custody Change - Report if a child for whom you are filing or who is in your care dies, leaves your care or custody, or changes address.
- The child age 13 or older has 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.
- A student, age 18 or over, stops attending school, reduces school attendance below full-time, changes schools, or is paid by an employer to attend school.
- If the worker and stepchild's parent divorce. Benefits are not payable to a stepchild beginning with the month after the month the worker and the stepchild's parent divorce. Promptly return any benefit payment received on behalf of the stepchild for the months after the month the divorce becomes final.
- The child is confined for more than 30 continuous days to a jail, prison, penal institution or correctional facility for conviction of a crime or confined to a public institution by a court order in connection with a crime.
- Change in Marital Status - Marriage, divorce, or annulment of marriage. You must report marriage even if you believe that an exception applies.
- Disability Applicants - In addition to the applicable reporting requirements listed above:
 1. The disabled adult child returns to work (as an employee or self-employed) regardless of amount of earnings.
 2. The disabled adult child's condition improves.

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

HOW TO REPORT

You can make your reports online, 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 "My Social Security" 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.

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 the child earns more than the annual exempt amount. You may contact SSA to file a report for the child. Otherwise, SSA will use the earnings reported by the child's employer(s) and the child's self-employment tax return (if applicable) as the report of earnings required by law, to adjust benefits under the earnings test. It is your responsibility to ensure that the information you give concerning the child's earnings is correct.