

**DEPARTMENT OF
HEALTH AND HUMAN SERVICES
SOCIAL SECURITY ADMINISTRATION**

STATEMENT OF CLAIMANT OR OTHER PERSON

NAME OF WAGE EARNER, SELF-EMPLOYED PERSON, OR SSI CLAIMANT	SOCIAL SECURITY NUMBER
NAME OF PERSON MAKING STATEMENT (If other than above wage earner, self-employed person, or SSI claimant)	RELATIONSHIP TO WAGE EARNER, SELF-EMPLOYED PERSON, OR SSI CLAIMANT

Understanding that this statement is for the use of the Social Security Administration, I hereby certify that-

I fully understand that a felony crime equals any crime punishable by a sentence of death or imprisonment for a term exceeding 1 year regardless of the actual sentence imposed. I am completely aware of the foregoing statement.

1. Do you have any unsatisfied felony warrant for an arrest?

Yes No

2. Do you have any unsatisfied Federal or State warrant for an arrest for any violations of the conditions for a probation/parole?

Yes No

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 and/or State law. I affirm that all information I have given in this document is true.

SIGNATURE OF PERSON MAKING STATEMENT

Signature (First name, middle initial, last name) (Write in ink)	Date (Month, day, year)
SIGN HERE ▶	Telephone Number (Include Area Code)

Mailing Address (Number and Street, Apt. No., P.O. Box, Rural Route)

City and State	ZIP Code
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Witnesses are required ONLY if this statement has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the individual must sign below, giving their full addresses.

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)