

**APPLICATION FOR WIDOW'S OR WIDOWER'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. The information you furnish on this application will ordinarily be sufficient for a determination on the lump-sum death payment.

\*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).

If you were receiving benefits as a wife/husband at the time of your spouse's death, you need complete only the circled items. All other claimants must complete the entire form.

|    |   |                                       |                                 |
|----|---|---------------------------------------|---------------------------------|
| 1. | (a) PRINT name of deceased wage earner or self-employed person (herein referred to as the "deceased") | FIRST NAME, MIDDLE INITIAL, LAST NAME |                                 |
|    | (b) Check ( <input checked="" type="checkbox"/> ) one for the deceased                                | <input type="checkbox"/> Male         | <input type="checkbox"/> Female |
|    | (c) Enter deceased's Social Security Number   |                                       |                                 |
| 2. | (a) PRINT your name   | FIRST NAME, MIDDLE INITIAL, LAST NAME |                                 |
|    | (b) Enter your Social Security Number   |                                       |                                 |
|    | (c) Enter your name at birth if different from item 2(a)  | FIRST NAME, MIDDLE INITIAL, LAST NAME |                                 |

**PART I -- INFORMATION ABOUT THE DECEASED**

|    |   |   |
|----|---|---|
| 3. | Enter date of birth of deceased   | MONTH, DAY, YEAR  |
| 4. | (a) Enter date of death   | MONTH, DAY, YEAR  |
|    | (b) Enter place of death  | CITY AND STATE  |
| 5. | Enter name of the State or foreign country where the deceased had a fixed, permanent home at the time of death.   |   |
| 6. | (a) Did the deceased ever file an application for Social Security benefits, a period of disability under Social Security, supplemental security income, or hospital or medical insurance under Medicare?<br>If unknown, check this block <input type="checkbox"/> | <input type="checkbox"/> Yes<br>(If "Yes," answer (b) and (c).)<br><input type="checkbox"/> No<br>(If "No," go on to item 7.) |
|    | (b) Enter name(s) of person(s) on whose Social Security record(s) other application was filed.  | FIRST NAME, MIDDLE INITIAL, LAST NAME   |
|    | (c) Enter Social Security Number(s) of person(s) named in (b).<br>If unknown, check this block <input type="checkbox"/>   |   |

**ANSWER ITEM 7 ONLY IF THE DECEASED DIED PRIOR TO AGE 66 AND WITHIN THE PAST 4 MONTHS.**

|    |   |   |
|----|---|---|
| 7. | (a) Was the deceased unable to work because of a disabling condition at the time of death?  | <input type="checkbox"/> Yes<br>(If "Yes," answer (b).)<br><input type="checkbox"/> No<br>(If "No," go on to item 8.)         |
|    | (b) Enter date disability began   | MONTH, DAY, YEAR  |
| 8. | (a) Was the deceased 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? | <input type="checkbox"/> Yes<br>(If "Yes," answer (b) and (c).)<br><input type="checkbox"/> No<br>(If "No," go on to item 9.) |
|    | (b) Enter dates of service  | FROM: (Month, year) TO: (Month, year)   |
|    | (c) Has anyone (including the deceased) received, or does anyone expect to receive, a benefit from any other Federal agency?  | <input type="checkbox"/> Yes <input type="checkbox"/> No  |

**ANSWER ITEM 9 ONLY IF DEATH OCCURRED WITHIN THE LAST 2 YEARS.**

|            |  |  |
|------------|--|--|
| <b>9.</b>  | (a) About how much did the deceased earn from employment and self-employment during the year of death? _____ →   | Amount<br>\$   |
|            | (b) About how much did the deceased earn the year before death? _____ →  | Amount<br>\$   |
| <b>10.</b> | (a) Did the deceased have wages or self-employment income covered under Social Security in all years from 1978 through last year? _____ →                | <input type="checkbox"/> Yes <input type="checkbox"/> No<br><i>(If "Yes," skip to item 11.) (If "No," answer (b).)</i> |
|            | (b) List the years from 1978 through last year in which the deceased did not have wages or self-employment income covered under Social Security. _____ → |  |

**11. CHECK IF APPLICABLE:**  
 I am not submitting evidence of the deceased's earnings that are not yet on his/her 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.

**12. Enter below the information requested about each marriage of the deceased, including the marriage to you.**

|   |   |   |
|---|---|---|
| <b>To whom married</b>  | When <i>(Month, Day, and Year)</i>  | Where <i>(Enter name of City and State)</i> |
| <b>Last marriage of the deceased</b>                              | How marriage ended  | When <i>(Month, Day, and Year)</i>          |
|   | Marriage performed by:<br><input type="checkbox"/> Clergyman or public official<br><input type="checkbox"/> Other <i>(Explain in Remarks)</i> | Spouse's date of birth                      |
|   | If spouse deceased, give date of death  |   |
|   | Spouse's Social Security Number <i>(If none or unknown, so indicate)</i> _____ →  |   |
| <b>Previous marriage of the deceased (IF NONE, WRITE "NONE.")</b> | How marriage ended  | When <i>(Month, Day, and Year)</i>          |
|   | Marriage performed by:<br><input type="checkbox"/> Clergyman or public official<br><input type="checkbox"/> Other <i>(Explain in Remarks)</i> | Spouse's date of birth                      |
|   | If spouse deceased, give date of death  |   |
|   | Spouse's Social Security Number <i>(If none or unknown, so indicate)</i> _____ →  |   |

**USE "REMARKS" SPACE ON BACK PAGE FOR INFORMATION ABOUT ANY OTHER PREVIOUS MARRIAGE**

**13.** Is there a surviving parent (or parents) who was receiving support from the deceased at the time of death or at the time the deceased became disabled under Social Security law? \_\_\_\_\_ →  Yes  No  
*(If "Yes," enter the name and address in "Remarks.")*

**PART II -- INFORMATION ABOUT YOURSELF**

**14.** (a) 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 15.

(b) Was a public record of your birth made before 5? \_\_\_\_\_ →  Yes  No  Unknown

(c) Was a religious record of your birth made before age 5? \_\_\_\_\_ →  Yes  No  Unknown

**15.** Enter below information about each of your marriages. Indicate your marriage to the deceased by entering deceased's name (if you are applying for widower's benefits, enter the maiden name of the deceased); it is not necessary to repeat other information about this marriage you have already given in item 12. Enter complete information on all other marriages, whether before or after you married the deceased.

|  |  |                             |  |
|--|--|-----------------------------|--|
| To whom married  |  | When (Month, Day, and Year) | Where (Enter name of City and State)   |
| <b>Your current or last marriage</b>                   | How marriage ended   | When (Month, Day, and Year) | Where (Enter name of City and State)   |
|  | Marriage performed by:<br><input type="checkbox"/> Clergyman or public official<br><input type="checkbox"/> Other (Explain in Remarks) | Spouse's date of birth      | If spouse deceased, give date of death |
|  | Spouse's Social Security Number (If none or unknown, so indicate) _____ →  |                             |  |
|  | To whom married  |                             | When (Month, Day, and Year)            |
| <b>Your previous marriage (IF NONE, WRITE "NONE.")</b> | How marriage ended   | When (Month, Day, and Year) | Where (Enter name of City and State)   |
|  | Marriage performed by:<br><input type="checkbox"/> Clergyman or public official<br><input type="checkbox"/> Other (Explain in Remarks) | Spouse's date of birth      | If spouse deceased, give date of death |
|  | Spouse's Social Security Number (If none or unknown, so indicate) _____ →  |                             |  |

**USE "REMARKS" SPACE FOR INFORMATION ABOUT ANY OTHER MARRIAGE**

IF YOU ARE APPLYING FOR SURVIVING DIVORCED SPOUSE'S BENEFITS, OMIT 16 AND GO ON TO ITEM 17.

**16.** (a) Were you and the deceased living together at the same address when the deceased died? \_\_\_\_\_ →  Yes (If "Yes," go on to item 17.)  No (If "NO," answer (b).)

(b) If either you or the deceased were away from home (whether or not temporarily) when the deceased died, give the following:  
Who was away? \_\_\_\_\_ →  Deceased  Surviving spouse

|                    |                       |   |
|--------------------|-----------------------|---|
| Date last at home: | Reason absence began: | Reason you were apart at time of death: |
|--------------------|-----------------------|---|

If separated because of illness, enter nature of illness or disabling condition.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**17.** (a) Have you (or has someone on your behalf) even 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 18.)

(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, so indicate) \_\_\_\_\_ →

**DO NOT ANSWER QUESTION 18 IF YOU ARE AGE 66 OR OLDER. GO ON TO QUESTION 19.**

|            |   |  |  |
|------------|---|--|--|
| <b>18.</b> | (a) Are you so disabled that you cannot work or was there some period during the last 14 months when you were so disabled that you could not work? _____ →  | <input type="checkbox"/> Yes<br><i>(If "Yes," answer (b) and (c).)</i>   | <input type="checkbox"/> No<br><i>(If "No," go on to item 19.)</i> |
|            | (b) If "Yes," enter the date you became disabled. _____ →   | (Month, day, year)   |  |
| <b>19.</b> | Were you in the active military or naval service (including Reserve or National Guard <b>active</b> duty or active duty for training) after September 7, 1939 and before 1968? _____ →  | <input type="checkbox"/> Yes   | <input type="checkbox"/> No  |
| <b>20.</b> | Did you or the deceased work in the railroad industry for 7 years or more? →  | <input type="checkbox"/> Yes   | <input type="checkbox"/> No  |
| <b>21.</b> | (a) Did you or the deceased have Social Security credits (for example, based on work or residence) under another country's Social Security System? _____ →  | <input type="checkbox"/> Yes<br><i>(If "Yes," answer (b).)</i>   | <input type="checkbox"/> No<br><i>(If "No," go on to item 22.)</i> |
|            | (b) If "Yes," list the country(ies). _____ →  |  |  |
| <b>22.</b> | (a) Have you qualified for, or do you expect to qualify for, a pension or annuity (or a lump sum in place of a pension or annuity) based on your own employment and earnings for the Federal Government of the United States, or one of its States or local subdivision? <i>(Social Security benefits are not government pensions).</i> _____ → | <input type="checkbox"/> Yes<br><i>(If "Yes," check which of the items in item (b) applies to you.)</i>  | <input type="checkbox"/> No<br><i>(If "No," go on to item 23.)</i> |
|            | (b) <input type="checkbox"/> I receive a government pension or annuity.<br><br><input type="checkbox"/> I received a lump sum in place of a government pension or annuity.<br><br><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:<br><br>_____<br>(Month, year)<br><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 or annuity amount changes.

**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**

Medical insurance under Medicare helps pay your doctor bills. It also helps pay for a number of other medical items and services not covered under the hospital insurance plan does not apply to most medical expenses incurred outside the United States.

If you sign up for medical insurance, you must pay a premium for each month you have this protection. If you get monthly Social Security, railroad retirement, or civil service benefits, your premium will be deducted from your benefit check. If you get none of these benefits, you will be notified how to pay your premium.

The Federal Government contributes to the cost of your insurance. The amount of your premium and the Government's payment are based on the cost of services covered by medical insurance. The Government also makes additional payments when necessary to meet the full cost of the program. (Currently the Government pays about two-thirds of the cost of this program.) You will get advance notice if there is any change in your premium amount.

If you are entitled to hospital insurance as a result of this application, you will be enrolled for medical insurance automatically unless you indicate below that you do not want this protection. If you decline to enroll now, you can get medical insurance protection later only if you sign up for it during specified enrollment periods. Your protection may then be delayed and you may have to pay a higher premium when you decide to sign up.

The date your medical insurance begins and the amount of the premium you must pay depend on the month you filed this application with the Social Security Administration. Any Social Security office will be glad to explain the rules regarding enrollment to you.

|            |   |                              |                             |
|------------|---|------------------------------|-----------------------------|
| <b>23.</b> | Do you want to enroll in the Medicare Supplementary Medical Insurance Plan? _____ → | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|------------|---|------------------------------|-----------------------------|

**ANSWER ITEM 24 ONLY IF THE DECEASED DIED BEFORE THIS YEAR.**

|            |  |       |      |      |      |  |
|------------|--|-------|------|------|------|--|
| <b>24.</b> | (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 <u>did not earn more than *\$ _____ in wages, and did not perform substantial services in self-employment.</u> 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."<br><br>*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. |  |

  

|            |  |       |      |      |      |  |
|------------|--|-------|------|------|------|--|
| <b>25.</b> | (a) How much do you expect your total earnings to be this year? _____ ➔  | \$    |      |      |      |  |
|            | (b) Place an "X" in each block for each month of last year in which you <u>did not or will not earn more than *\$ _____ in wages, and did not or will not perform substantial services in self-employment.</u> 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."<br><br>*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 ITEM 26 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).**

|            |  |       |      |      |      |  |
|------------|--|-------|------|------|------|--|
| <b>26.</b> | (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 <u>do not expect to earn more than *\$ _____ in wages, and do not expect to perform substantial services in self-employment.</u> 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."<br><br>*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. |  |

  

|            |  |       |  |  |  |  |
|------------|--|-------|--|--|--|--|
| <b>27.</b> | 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, GO ON TO PAGE 6. OTHERWISE, PLEASE READ CAREFULLY THE INFORMATION ON PAGE 7 AND ANSWER ONE OF THE FOLLOWING ITEMS.**

|            |  |                          |
|------------|--|--------------------------|
| <b>28.</b> | (a) I want benefits beginning with the earliest possible month that will be the most advantageous. _____ ➔   | <input type="checkbox"/> |
|            | (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 that there is no permanent reduction in my ongoing monthly benefits. _____ ➔ | <input type="checkbox"/> |
|            | (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. _____ ➔  | <input type="checkbox"/> |

**ANSWER QUESTION 29 ONLY IF YOU ARE NOW AT LEAST AGE 61 YEARS, 8 MONTHS.**

|            |   |                              |                             |
|------------|---|------------------------------|-----------------------------|
| <b>29.</b> | Do you wish this application to be considered an application for retirement benefits on your own earnings record? _____ ➔ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|------------|---|------------------------------|-----------------------------|

An ANNUAL REPORT of earnings must be filed with the Social Security Administration within 3 months and 15 days after the end of any taxable year in which you earn more than the yearly limit, if you are under age 70 for at least 1 full month of that year and receive some benefits during the taxable year. I AGREE TO FILE AN ANNUAL REPORT OF EARNINGS. THE ANNUAL REPORT IS REQUIRED BY LAW AND FAILURE TO REPORT MAY RESULT IN A MONETARY PENALTY.

Remarriage prior to age 60 may terminate your benefits. There are certain exceptions which are explained in the informational booklet which you will receive. You must report if you remarry 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 if I REMARRY and to PROMPTLY RETURN ANY BENEFIT CHECK I receive for the month I marry, and for any later month.

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 <i>(Month, day, year)</i>                                   |
| Signature <i>(First name, middle initial, last name)</i> <i>(Write in ink)</i> | Telephone Number(s) at which you may be contacted during the day |
| <b>SIGN HERE</b>   | AREA CODE  |

|                              |   |     |  |
|------------------------------|---|-----|--|
| <b>FOR OFFICIAL USE ONLY</b> | Direct Deposit Payment Address <i>(Financial Institution)</i> |     |  |
|                              | Routing Transit Number  | C/S | Depositor Account Number   |
|                              |   |     | <input type="checkbox"/> No Account<br><input type="checkbox"/> 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 <i>(if any)</i> 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 <i>(Number and street, City, State and zip Code)</i> | Address <i>(Number and street, City, State and zip Code)</i> |