

(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 _____ →	<input type="checkbox"/> Male <input type="checkbox"/> 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? _____ →	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
	(d) Was a religious record of your birth made before you were age 5? _____ →	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
4.	(a) What is your disabling condition? (Briefly describe the injury or illness that prevents, or has prevented, you from working.) _____	
	(b) Is your injury or illness related to your work in any way? _____ →	<input type="checkbox"/> Yes <input type="checkbox"/> No
5.	(a) When did you become unable to work because of your disabling condition? _____ →	MONTH, DAY, YEAR
	(b) Are you still disabled? (If "Yes," go on to item 6.) (If "No," answer (c).) _____ →	<input type="checkbox"/> Yes <input type="checkbox"/> No
	(c) If you are no longer disabled, enter the date your disability ended. _____ →	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? _____ →	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown (If "Yes," answer (b) and (c).) (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. <input type="checkbox"/> _____ →	
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? _____ →	<input type="checkbox"/> Yes <input type="checkbox"/> No (If "Yes," answer (b) and (c).) (If "No," go on to item 8.)
	(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) _____ →	<input type="checkbox"/> Yes <input type="checkbox"/> No

8. (a) Have you filed (or do you 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.)

(b) I became entitled, or expect to become entitled, beginning

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

MONTH	YEAR
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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.

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")
<input type="checkbox"/> This Year		
<input type="checkbox"/> Last Year		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Year before last		<input type="checkbox"/> Yes <input type="checkbox"/> 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 disability? (If "Yes," give amounts and explain in "Remarks" on page 4.) →	<input type="checkbox"/> Yes <input type="checkbox"/> 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.) →	<input type="checkbox"/> Yes <input type="checkbox"/> No Amount \$ _____

PART II—INFORMATION ABOUT THE DISABLED WORKER AND SPOUSE

16. Have you ever been married? (If "Yes," answer item 17.) (If "No," go on to item 18.) →	<input type="checkbox"/> Yes <input type="checkbox"/> No
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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 <input type="checkbox"/> Clergyman or public official <input type="checkbox"/> 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 <input type="checkbox"/> Clergyman or public official <input type="checkbox"/> 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? →	<input type="checkbox"/> Yes <input type="checkbox"/> No
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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: <ul style="list-style-type: none"> ● 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.)	<input type="checkbox"/> Yes <input type="checkbox"/> No
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**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 imprisoned for conviction of a felony.

The above events may affect my eligibility to 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

Signature (First name, middle initial, last name) (Write in ink)

Date (Month, day, year)

**SIGN
HERE**

Telephone Number(s) at which you may be contacted during the day. (Include the area code)

Direct Deposit Payment Address (Financial Institution)

**FOR
OFFICIAL
USE ONLY**

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)