SOCIAL SECURITY ADMINISTRATION

Form Approved
OMB No. 0960-0051

SUPPLEMENT TO CLAIM OF PERSON OUTSIDE THE UNITED STATES

(To be completed by or on behalf of person who is, was, or will be outside the U.S.)

For Social Security purposes, a person is outside the United States if he or she is physically outside the 50 States, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa .

1. Name of Worker on Whose Earnings This Claim Is Based

2. Worker's Social Security Number
__ __ __ / __ __ /__ __ __ __

3.

LIST BELOW THE FULL NAME OF THE WORKER (EVEN IF DECEASED) AND OF EACH BENEFICIARY IN THE SAME HOUSEHOLD WHO IS, WAS OR WILL BE OUTSIDE THE UNITED STATES.	COUNTRY OF BIRTH	COUNTRY OF RESIDENCE		COUNTRY(IES) OF PRESENT CITIZENSHIP (Or at time of death)	IF PERSON HAS U.S. PASSPORT, LIST:	
		PRESENT	OVER NEXT 12 MONTHS		PASSPORT NO.	DATE ISSUED
a.						
b.						
c.						
d.						

Note: All persons listed above or their representative payees must sign the certification on reverse side (item 12).

4. If any beneficiary listed in item 3 above was outside the U.S. this month or any of the past 24 months, or will be in the next 6 months, complete item 4 by entering the name of the beneficiary and dates (month, day and year) he/she was or will be outside the U.S. NOTE: Entries should not be made by residents of Canada or Mexico who are entering the U.S. on a daily basis to work or visit and returning each day to their residence in Canada or Mexico.

NAME	OUTSIDE U.S. FROM Mo-Day-Yr	OUTSIDE U.S. TO Mo-Day-Yr	OUTSIDE U.S. FROM Mo-Day-Yr	OUTSIDE U.S. TO Mo-Day-Yr	DATE OF EXPECTED RETURN TO U.S. (If within the next 18 months)
a.					
b.					
c.					
d.					

5. Has any person listed above been employed or self-employed outside the U.S. during any of the past 12 months? If "yes," give name and date(s) work began. → ☐ Yes ☐ No

NAME | DATE(S)

NAME | DATE(S)

6. Does any person listed above expect to begin employment or self-employment outside the U.S. in the future? If "yes," give name and date(s) work is expected to begin. → ☐ Yes ☐ No

NAME	DATE	NAME	DATE

RESIDENCE IN THE U.S.

7.

LIST BELOW THE NAME OF THE WORKER AND OF EACH BENEFICIARY LISTED IN ITEM 3 ABOVE	TOTAL NO. OF YEARS LIVED IN THE U.S.	RELATIONSHIP TO WORKER NAMED IN ITEM 1 DURING THIS PERIOD	DATES PERSON RESIDED IN THE U.S.			
			FROM Mo-Day-Yr	TO Mo-Day-Yr	FROM Mo-Day-Yr	TO Mo-Day-Yr
a.						
b.						
c.						
d.						

If you need more space, use the Remarks section on the reverse side.

8. Answer question 8 only if the worker named in item 1 is deceased.
Did the worker die while in the military service of the U.S. or as a result of disease or injury incurred or aggravated in the military service? → ☐ Yes ☐ No

9. Supplementary Medical Insurance generally is payable only for medical services provided inside the United States. If anyone listed in item 3 is now enrolled in Supplementary Medical Insurance under Medicare and wishes to terminate that enrollment, enter his/her name here.

NAME(S)

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

10. ADDRESS (Where Checks Should Be Mailed While You Are Abroad)

NUMBER AND STREET	CITY	POSTAL CODE	COUNTRY

NOTE: If more than one mailing address is required, use the Remarks section and show names for each address.

11. RESIDENCE ABROAD (If checks are sent to a bank or Post Office box or if your check mailing address is not your residence, you must provide your residence address.)

	NAME	NUMBER AND STREET	CITY	POSTAL CODE	COUNTRY
a.					
b.					
c.					
d.					

Explain in Remarks section why checks cannot be sent to your residence address. If you use an APO/FPO address, explain why you do not have a residence address.

CERTIFICATION AND SIGNATURES

I agree to notify the Social Security Administration Promptly if I *(or any Person for whom I receive benefits)* become employed or self-employed while outside the United States, change citizenship or go *(for 30 days or more)* into any country other than that indicated above. I also agree to return any checks which are not due.

All information I have given is true. I understand I could be fined. imprisoned, or both for making a false statement or misrepresenting material facts for use in determining a right to Social Security payments.

12.	SIGNATURE *(FIRST NAME, MIDDLE INITIAL, AND LAST NAME)* OF EACH PERSON LISTED IN ITEM 3. *REPRESENTATIVE PAYEES MUST SIGN FOR MINORS AND FOR INCAPABLE OR INCOMPETENT ADULTS. Write in ink.*	DATE	TELEPHONE NUMBER WHERE YOU MAY BE CONTACTED DURING THE DAY
a.			
b.			
c.			
d.			

Witnesses are required only if this application has been signed by mark (X) in item 12. If signed by mark (X), two witnesses who know the signer(s) must sign below, giving their full addresses.

13.	(1) SIGNATURE OF WITNESS			(2) SIGNATURE OF WITNESS		
	ADDRESS *(NUMBER AND STREET)*			ADDRESS *(NUMBER AND STREET)*		
	CITY	POSTAL CODE	COUNTRY	CITY	POSTAL CODE	COUNTRY

PRIVACY AND PAPERWORK REDUCTION ACT STATEMENTS

This notice is given pursuant to the Privacy Act of 1974 (5 U.S.C. 552a). This supplement is authorized in order to establish entitlement to Social Security benefits under Section 202 of the Social Security Act, as amended (42 U.S.C. 402). Other uses which may be made of the information are summarized below.

With the exception noted hereafter, your response to the questions on this supplemental form is voluntary; however, failure to file this supplement will result in the nonpayment of benefits for periods when the beneficiary is outside the United States. Your response is required when the refusal to disclose the information reflects a fraudulent intent to secure benefits not authorized by the Act.

The information you furnish on this form may be disclosed by SSA to another person or to another governmental agency for the following purposes:

1. To assist SSA in establishing the right of an individual to Social Security benefits and/or the amount thereof;
2. To facilitate statistical research and audit activities necessary to assure the integrity and improvement of the Social Security programs; and
3. To comply with authorized arrangements under which information is furnished to other agencies.

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.

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 5 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.