

PRINT NAME OF DECEASED BENEFICIARY	SOCIAL SECURITY CLAIM NUMBER OF DECEASED BENEFICIARY
If above-named beneficiary received benefits on another person's record, print name of the insured person →	NAME OF INSURED
The deceased beneficiary may have been due a Social Security payment at the time of death. The Social Security Act provides that amounts due a deceased beneficiary may be paid to the next of kin or the legal representative of the estate under priorities established in the law. To help us decide who should receive any payment due, please COMPLETE this form and RETURN it to us in the enclosed envelope.	
PRINT NAME OF CLAIMANT	PRINT ADDRESS OF CLAIMANT (Include house number, street, apt. number, P.O. Box, rural route, city state and Zip code.)

CLAIM FOR AMOUNTS DUE IN THE CASE OF DECEASED BENEFICIARY

PAPERWORK/PRIVACY ACT STATEMENT

The Social Security Administration (SSA) is authorized to collect the information on this form under Sections 204 (d) of the Social Security Act, as amended (42 U.S.C 404(d)) and section 413(b) of the Federal Mine Safety and Health Act of 1977 (30 U.S.C. 923) . While it is voluntary for you to furnish the information on this form to SSA, failure to provide the information may result in nonpayment of the unpaid benefits. The information on this form is needed to determine if any individual meets the specified qualifications to obtain benefits in the case of a deceased beneficiary as well as the priority order for payment. Although the information you furnish on this form is almost never used for any other purpose than stated in the foregoing, there is a possibility that for the administration of

the Social Security program or for the administration of programs requiring coordination with SSA, information may be disclosed to another governmental agency as follows: (1) to assist SSA in deciding who should receive any payments due the deceased beneficiary; (2) to comply with Federal laws requiring the release of information from Social Security records (e.g., to the General Accounting Office and the Veterans Administration); and (3) to facilitate statistical research and audit activities necessary to assure the integrity and improvement of the Social Security programs (e.g., to the Bureau of the Census and private concerns under contract of Social Security).

I am claiming amounts due from the Social Security Administration as the _____ of _____ who died on the _____ day of _____, and whose fixed permanent home was in the state of _____.

(Indicate your relationship to the deceased (i.e. widow, son, etc. or legal representative)

(Name of decedent) (Month) (Year)

THE FOLLOWING ARE THE NEXT OF KIN OR LEGAL REPRESENTATIVES OF THE DECEASED PERSON NAMED ABOVE:

1	NAME OF SURVIVING WIDOW(ER) (Please print. If none, state "NONE".)	ADDRESS OF SURVIVING WIDOW(ER) (Please print house number, street, apt. number, P.O., box, rural route, city, state and Zip code)	
	ENTER SOCIAL SECURITY NUMBER(S) OF WIDOW(ER) NAMED ABOVE. (If unknown, indicate "UNKNOWN".) →	_____ / _____ / _____	
	WAS THE WIDOW(ER) NAMED ABOVE, LIVING IN THE SAME HOUSEHOLD WITH THE DECEASED AT THE TIME OF DEATH? →	<input type="checkbox"/> YES (If "YES", OMIT items 2, 3,4, and 5 and SIGN at bottom of page 2.) <input type="checkbox"/> NO	
	WAS HE OR SHE ENTITLED TO A MONTHLY BENEFIT ON THE SAME EARNINGS RECORD AS THE DECEASED AT THE TIME OF DEATH? →	<input type="checkbox"/> YES (If "YES", OMIT items 2, 3,4, and 5 and SIGN at bottom of page 2.) <input type="checkbox"/> NO (Go on to item 2.)	
2	ENTER NUMBER OF LIVING CHILDREN OF THE DECEASED. INCLUDE ADOPTED CHILDREN AND STEPCHILDREN; INCLUDE GRANDCHILDREN AND STEPGRANDCHILDREN IF THEIR PARENTS ARE DISABLED OR DECEASED; OR IF THEY HAVE BEEN ADOPTED BY THE SURVIVING SPOUSE OF THE DECEASED BENEFICIARY. IF NONE OF THE ABOVE, SHOW "NONE" AND GO ON TO ITEM 4.		NUMBER
	PRINT NAME AND COMPLETE ADDRESS OF EACH CHILD		
	NAME OF CHILD	ADDRESS OF CHILD (Include house number, street, apt. number, P.O., box, rural route, city, state and Zip code)	
	RELATIONSHIP TO DECEASED (Grandchild,stepchild,etc.)	SOCIAL SECURITY NUMBER(S) OF CHILD (If unknown, indicate "UNKNOWN".) _____ / _____ / _____	
	NAME OF CHILD	ADDRESS OF CHILD (Include house number, street, apt. number, P.O., box, rural route, city, state and ZIP code)	
RELATIONSHIP TO DECEASED (Grandchild,stepchild,etc.)	SOCIAL SECURITY NUMBER(S) OF CHILD (If unknown, indicate "UNKNOWN".) _____ / _____ / _____		

3	IF ANY CHILD LISTED IN ITEM 2 NOW HAS A NAME DIFFERENT FROM THAT GIVEN AT BIRTH, PRINT BELOW THAT CHILD'S NAME, THE NAME GIVEN AT BIRTH, AND A BRIEF EXPLANATION FOR THE DIFFERENCE.	
	CHILD'S PRESENT NAME	CHILD'S NAME AT BIRTH
	EXPLANATION <i>(Marriage, court order, adoption)</i>	

4	ENTER NUMBER OF LIVING PARENTS OF THE DECEASED <i>(Include adopting parents and stepparents. If none, show "None".)</i> _____		NUMBER
	IF THERE ARE NO LIVING PARENTS, GO ON TO ITEM 5. _____		
	PRINT NAME AND COMPLETE ADDRESS OF EACH PARENT		
	NAME OF LIVING PARENT	ADDRESS OF LIVING PARENT <i>(Include house number, street, apt. number, P.O. box, rural route, city, state, and Zip Code)</i>	
	ENTER SOCIAL SECURITY NUMBER(S) OF PARENT NAMED. <i>(If unknown, indicate "UNKNOWN".)</i> _____	_____ / _____ / _____	

5	LEGAL REPRESENTATIVE OF THE DECEASED'S ESTATE (Omit this item if relatives are listed in 1,2, or 4)	
	NAME OF LEGAL REPRESENTATIVE <i>(Please print)</i>	ADDRESS OF LEGAL REPRESENTATIVE <i>(Please print house number, street, apt. number, P.O. box, rural route, city, state, and Zip Code)</i>
	ENTER SOCIAL SECURITY NUMBER(S) OF PARENT NAMED. <i>(If unknown, indicate "UNKNOWN".)</i> _____	_____ / _____ / _____

Note: If you are applying as legal representative, please submit a certified copy of your letters of appointment.

REMARKS: *(If you need more space for explaining any answers to the questions, attach a separate sheet.)*

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 10 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.

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 <i>(First name, middle initial, last name)</i>	DATE <i>(Month, day, year)</i>	TELEPHONE NUMBER <i>(Include area code)</i>
--	--------------------------------	---

MAILING ADDRESS *(House number and street, apt. number, P.O. box, or rural route)*

CITY	STATE	NAME OF COUNTY	ZIP CODE
------	-------	----------------	----------

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.

SIGNATURE OF WITNESS	SIGNATURE OF WITNESS
ADDRESS <i>(House number and street, city, state, and Zip code)</i>	ADDRESS <i>(House number and street, city, state, and Zip code)</i>