	CLAIM FOR AMOUNTS DUE IN THE	CASE OF A	DECEASED BENEFICIA	\RY			
PRINT NAME OF DECEASED		SOCIAL SECURITY NUMBER OF DECEASED					
If the deceased received benefits on another person's record, print name of that worker		NAME OF THE WORKER					
Sec the	deceased may have been due a Social Security payrurity Act provides that amounts due a deceased may estate under priorities established in the law. To help se COMPLETE THIS ENTIRE FORM and RETURN it to	be paid to the us decide wh	e next of kin or the legal repre no should receive any payme	esentative of			
This	claim for the amounts due is being made on behalf of the fami	ily or the estate o	f				
	who died on day (name of deceased)	y of(month	 )				
	,	(111011111	(500.7				
	who lived in the state of	DEL ATIONEL	IID TO DECEASED (Midow Son	Logal			
PKII	IT NAME OF APPLICANT	RELATIONSHIP TO DECEASED (Widow, Son, Legal Representative, etc.)					
	THE FOLLOWING ARE THE NEXT OF KIN OR LEGAL	REPRESENTA	TIVE OF THE DECEASED NA	AMED 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)					
	(Flease pilit. If Holle, State NONE )		,, , , . <b>,</b> , ,	,			
	ENTER SOCIAL SECURITY NUMBER(S) OF WIDOW(ER) NAMED ABOVE.						
	WAS THE WIDOW(ER) NAMED ABOVE LIVING IN THE SAME HOUSEHOLD WITH THE DECEASED AT THE TIME OF DEATH?	YES	If "YES", then SKIP items 2,3,4,5 and SIGN at bottom of page 2.	□ NO			
	WAS HE OR SHE ENTITLED TO A MONTHLY BENEFIT ON THE SAME EARNINGS RECORD AS THE DECEASED AT THE TIME OF DEATH?	YES	If "YES", then SKIP items 2,3,4,5 and SIGN at bottom of page 2.	NO (Go on to item 2)			
2.	ENTER NUMBER OF LIVING CHILDREN OF THE DECEASED. INCLUDE ADOPTED CHILDREN AND STEPCHILDREN; INCLUDE GRANDCHILDREN AND STEP-GRANDCHILDREN IF THEIR PARENTS ARE DISABLED OR DECEASED; OR IF THEY HAVE BEEN ADOPTED BY THE SURVIVING SPOUSE OF THE DECEASED. IF NONE OF THE ABOVE, SHOW "NONE" AND GO ON TO ITEM 4.						
	PRINT NAME AND COMPLETE ADDRESS OF EACH CHILD  Remarks -(If you need more space for explaining any answers to the questions, attach a separate sheet.)						
	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 SEC	SOCIAL SECURITY NUMBER OF 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 SEC	URITY NUMBER OF CHILD				

3.	If any child listed in item 2 has Child's Present Name, Name (							
4.	ENTER NUMBER OF LIVING PARENTS OF THE DECEASED  (Include adopting parents and stepparents. If none, show "None") IF THERE ARE NO LIVING PARENTS, GO ON TO ITEM 5.					NUMBER		
	PRINT NAME AND COMPLETE ADDRESS OF EACH PARENT							
				ADDRESS OF LIVING PARENT (Include house number, street, apt. number, P.O. Box, rural route, city, state, and ZIP code)				
	ENTER SOCIAL SECURITY N	NUMBER OF PAREN	T NAMED					
				ADDRESS OF LIVING PARENT (Include house number, street, apt. number, P.O. Box, rural route, city, state, and ZIP code)				
	ENTER SOCIAL SECURITY N	NUMBER OF PAREN	T NAMED.					
5.	LEGAL REPRESEN	atives are listed in 1	, 2, or 4.)					
	NAME OF LEGAL REPRESENTATIVE (Please print)		n	ADDRESS OF LEGAL REPRESENTATIVE (Please print house number, street, apt. number, P.O. Box, rural route, city, state, and ZIP code.)				
	NOTE: If you are applying a	s legal representativ	ve, please sub	omit a certified copy of yo	ur letters of appointr	nent.		
	│ lare under penalty of perjury s, and it is true and correct to			mation on this form, and c	on any accompanyin	g statements or		
		SIC	SNATURE OF	APPLICANT				
SIGNATURE (First name, middle initial, last name)  DATE (Mo			DATE (Mon	th, day, year) TELEPHONE N (Include area co		ER		
MAIL	ING ADDRESS (House numbe	r and street, apt. num	hber, P.O. Box	, or rural route)				
CITY		STATE		NAME OF COUNTY	ZIP CODE			
		Direct Deposit F	Payment Addr	ess (Financial Institution)				
	Туре	of Account		Nine Digit Routing Number				
	Checking	Savings						
Acco	unt Number							
	TNESSES ARE REQUIRED ON TWO WITNESSES TO THE SIG							
SIGNATURE OF WITNESS				SIGNATURE OF WITNESS				
ADDRESS (House number and street, city, state, and ZIP code)			code)	ADDRESS (House number and street, city, state, and ZIP code)				
			<b>D</b>	0				

## **PRIVACY ACT NOTICE**

Section 204(d) of the Social Security Act, as amended, authorizes us to collect this information. We will use this information to help us determine the beneficiary's payment.

Furnishing us the information is voluntary. However, failing to provide us with all or part of the requested information may prevent us from making an accurate and timely decision on your claim, which may result in the loss of payments.

We rarely use the information you supply for any purpose other than for determining problems in Social Security programs. However, we may use it for the administration and integrity of Social Security programs. We may also disclose information to another person or to another agency in accordance with approved routine uses, which include, but are not limited to the following:

- 1) To contractors and other Federal agencies, as necessary, for the purpose of assisting the Social Security Administration in the efficient administration of its programs;
- 2) To comply with Federal laws requiring the release of information from Social Security records (e.g., to the Government Accountability Office and Department of Veteran's Affairs);
- To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level; and.
- 4) To facilitate statistical research, audit, or investigatory activities necessary to assure the integrity and improvement of Social Security programs.

We may also use the information you provide in computer matching programs. Matching programs compare our records with records kept by other Federal, State, or local government agencies. We use the information from these matching programs to establish or verify a person's eligibility for federally-funded and administered benefit programs and for repayment, incorrect payments or delinquent debts under these programs.

A complete list of routine uses for this information is available in our Privacy Act Systems of Records Notices, 60-0089, Claims Folder Systems, and 60-0090, Master Beneficiary Record. These notices, additional information regarding our programs and systems, are available on-line at <a href="https://www.socialsecurity.gov">www.socialsecurity.gov</a> or at any local Social Security office.

Paperwork Reduction Act Statement This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget (OMB) control number. We estimate that it will take about 10 minutes to read the instructions, gather the facts, and answer the questions. **Send only comments relating to our time estimate above to**: SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.