CLAIM FOR AMOUNTS DUE IN THE CASE OF A DECEASED BENEFICIARY

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

The deceased may have been due a Social Security payment and/or a Medicare Premium refund. The Social Security Act provides that amounts due a deceased 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 ENTIRE FORM and RETURN it to us in the enclosed envelope.

This claim for the amounts due is being made on behalf of the family or the estate of

_____
(name of deceased)

who died on _____ day of _____ _____ and who lived in the state of _____.
(month) (year)

PRINT NAME OF APPLICANT	RELATIONSHIP TO DECEASED (Widow, Son, Legal Representative, etc.)

THE FOLLOWING ARE THE NEXT OF KIN OR LEGAL REPRESENTATIVE OF THE DECEASED 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.

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. — NUMBER

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 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 SECURITY NUMBER OF CHILD

3. If any child listed in item 2 has a different name from that given at birth, attach a separate sheet with the following information: Child's Present Name, Name Given At Birth, and a brief explanation for the difference (e.g. Marriage or Court Order).

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

NAME OF LIVING PARENT	ADDRESS OF LIVING PARENT (Include house number, street, apt. number, P.O. Box, rural route, city, state, and ZIP code)
ENTER SOCIAL SECURITY NUMBER OF PARENT NAMED	
NAME OF LIVING PARENT	ADDRESS OF LIVING PARENT (Include house number, street, apt. number, P.O. Box, rural route, city, state, and ZIP code)
ENTER SOCIAL SECURITY NUMBER OF PARENT NAMED	

5. **LEGAL REPRESENTATIVE OF THE DECEASED'S ESTATE (Skip this item if relatives are listed in 1, 2, or 4.)**

NAME OF LEGAL REPRESENTATIVE (Please print)	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 as legal representative, please submit a certified copy of your letters of appointment.

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge.

SIGNATURE (First name, middle initial, last name)	DATE (MM/DD/YYYY)	TELEPHONE NUMBER (Include area code)

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

CITY	STATE	NAME OF COUNTY	ZIP CODE

Direct Deposit Payment Address (Financial Institution)

Type of Account	Nine Digit Routing Number	Account Number
☐ Checking ☐ Savings		

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 (House number and street, city, state, and ZIP code)	ADDRESS (House number and street, city, state, and ZIP code)

Privacy Act Statement
Collection and Use of Personal Information

Sections 204(d) and 1870(g) of the Social Security Act, as amended, allow us to collect this information. Furnishing us this information is voluntary. However, failing to provide all or part of the information may prevent proper payment of a Title II underpayment or Medicare premium refund due a deceased beneficiary.

We will use the information you provide to determine your eligibility for payment of a Title II underpayment or Medicare premium refund due a deceased beneficiary. We may also share your information for the following purposes, called routine uses:

- To the Department of the Treasury, for: (a) Collecting Social Security taxes or as otherwise pertinent to tax and benefit payment provisions of the Social Security Act, including SSN verification services; and (b) investigating alleged theft, forgery, or unlawful negotiation of Social Security checks; and

- To contractors and other Federal agencies, as necessary, for the purpose of assisting us in the efficient administration of our programs. We will disclose information under this routine use only in situations in which we may enter into a contractual or similar agreement to obtain assistance in accomplishing an SSA function relating to this system of records.

In addition, we may share this information in accordance with the Privacy Act and other Federal laws. For example, where authorized, we may use and disclose this information in computer matching programs, in which our records are compared with other records to establish or verify a person's eligibility for Federal benefit programs and for repayment of incorrect or delinquent debts under these programs.

A list of additional routine uses is available in our Privacy Act System of Records Notices (SORNs) 60-0089, entitled Claims Folders System, as published in the Federal Register (FR) on October 31, 2019, at 84 FR 58422; 60-0090, entitled Master Beneficiary Record, as published in the FR on January 11, 2006, at 71 FR 1826; and 60-0321, entitled Medicare Database (MDB) File, as published in the FR on July 25, 2006, at 71 FR 42159. Additional information, and a full listing of all our SORNs, is available on our website at www.ssa.gov/privacy.

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 regarding this burden estimate or any other aspect of this collection, including suggestions for reducing this burden to*****:** *SSA*, *6401 Security Blvd, Baltimore, MD 21235-6401.*