SOCIAL SECURITY ADMINISTRATION ☐ TEL TOE 120/145 Form Approved OMB No. 0960-0060

APPLICATION FOR DISABILITY INSURANCE BENEFITS

(Do not write in this space)

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.

1.	PRINT your name →	FIRST NAME, MIDDLE INITIAL, LAST NAME: Doe, John D.
2.	Enter your Social Security Number →	123-45-6789
3.	Check (X) whether you are →	☑ Male ☐ Female
4.	If this claim is awarded, do you want a password to use SSA's Internet/phone service?	☑ Yes ☐ No

Answer question 5 if English is not your preferred language. Otherwise, go to item 6.

5.	Enter the language you prefer to:	speak English write English
6.	(a) Enter your date of birth →	MONTH DAY YEAR: 6-12-52
	(b) Enter name of State or foreign country where you were born. →	California
	(c) Was a public record of your birth made before you were age 5?	☑ Yes ☐ No ☐ Unknown
	(d) Was a religious record of your birth made before you were age 5?	☐ Yes ☐ No ☑ Unknown
7.	(a) Are you a U.S. citizen? →	☑ Yes Go to item 8 ☐ No Go to item (b)
	(b) Are you an alien lawfully present in the U.S.?	☐ Yes ☐ No
8.	(a) Enter your name at birth if different from item (1)	n/a
	(b) Have you used any other names? →	☐ Yes Go to (c) ☑ No Go to item 9
	(c) Other name(s) used.	
9.	(a) Have you used any other Social Security number(s)? →	☐ Yes Go to (b) ☑ No Go to item 10
	(b) Enter Social Security number(s) used. →	
10.	Enter the date you became unable to work because of your illness, injuries, or conditions. →	August 2010
11.	(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? →	☐ Yes (If "Yes," answer (b) and (c).) ☑ No (If "No," or "Unknown," go to item 12.) ☐ Unknown
	(b) Enter name of person on whose Social Security record you filed the other application. →	June 1972
	(c) Enter Social Security Number of person named in (b). → *If unknown, check this block.* ☐	

Answer item 12, if you have been in the military service. Otherwise, go to item 13.

12.	(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? →	☑ Yes (If "Yes," answer (b) and (c).)	☐ No (If "No," go to item 13.)
	(b) Enter dates of service →	FROM: (Month, Year) June 1970	TO: (Month, Year) June 1972
	(c) Have you *ever* been (or will you be) eligible for a monthly benefit from a military or civilian Federal agency? (Include Veterans Administration benefits *only* if you waived military retirement pay.) →	☑ Yes	☐ No
13.	Have you or your spouse worked in the railroad industry for 5 years or more? →	☐ Yes	☑ No
14.	(a) Do you have Social Security credits (for example, based on work or residence) under another country's Social Security System? →	☐ Yes (If "Yes," answer (b).)	☑ No (If "No," go to item 15.)
	(b) List the country(ies): →		
15.	(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 16.)
	(b) ☐ I became entitled, or expect to become entitled, beginning →	MONTH	YEAR
	(c) ☐ I became eligible, or expect to become eligible, beginning →	MONTH	YEAR

I AGREE TO PROMPTLY 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 of annuity stops.

16.	(a) Have you ever been married? →		☑ Yes Go to (b)	☐ No Go to item 17
	(b) To whom married: Jane J. Doe	When (Month, day, year): April 5, 1975	Where (Name of City and State): Denver, CO	
Current or Last Marriage	How marriage ended (If still in effect, write "Not Ended."): Not Ended.	When (Month, day, year)	Where (Name of City and State)	
	Marriage performed by: ☐ Clergyman or public official ☐ Other (Explain in Remarks)	Spouse's date of birth (or age): 9-5-54	If spouse deceased, give date of death	
	Spouse's Social Security Number (If none or unknown, so indicate): 111-22-3333			

Give the following information about each of your previous marriages. **(If none, write "NONE.")**

	(c) To whom married: None	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: ☐ Clergyman or public official ☐ 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 "Remarks" space for information about any other marriages.

17. 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:

- UNDER AGE 18
- AGE 18 TO 19 AND ATTENDING ELEMENTARY OR SECONDARY SCHOOL FULL-TIME
- DISABLED OR HANDICAPPED (age 18 or over and disability began before age 22)

John Doe, Jr.	

18. (a) Did you have wages or self-employment income covered under Social Security in all years from 1978 through last year? — ☐ Yes (If "Yes," go to item 19.) ☑ 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. — 1975, 1992

19. (a) 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 TO ITEM 20.

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
Bay Area Shipping Containers, 12310 Front St., San Francisco, CA	August	1979	July	1986
Acme Security Services, 1984 Ashley Ave., San Francisco, CA	January	1990	Nov.	1995
Jewel's Food Services, 400 W. 19th St., Los Angeles, CA	Feb.	1996	Aug	2011

(If you need more space, use "Remarks".)

(b) Are you an officer of a corporation or related to an officer of a corporation? → ☐ Yes ☑ No

20. May the Social Security Administration or State agency reviewing your case, ask your employers for information needed to process the claim? → ☑ Yes ☐ No

21. Complete item 21 even if you were an employee.

(a) Were you self-employed this year or last year? → ☐ Yes Go to (b) ☑ No Go to item 22

(b) Check the year (or years) you were self-employed	In what type of trade/business were you self-employed? (For example, storekeeper, farmer, physician)	Were your net earnings from the trade or business $400 or more? (Check "Yes" or "No")
☐ This year		
☐ Last year		☐ Yes ☐ No

22. (a) How much were your total earnings last year? Count both wages and self-employment income. (If none, write "None.") → Amount $ 24,500

(b) How much have you earned so far this year? (If none, write "None.") → Amount $ 9,500

23. Check if applicable:

☐ Please compute my benefits and complete my claim without using recent earnings that are not yet included on my (the deceased's, if applicable) earnings record. I understand that the earnings record will be updated automatically within 24 months and that any increase in benefits resulting from these earnings will be paid with the full retroactivity.

24.	What are the illnesses, injuries, or conditions that limit your ability to work? (Give a brief description.) High blood pressure Back pain Arthritis hands and knees	
25.	(a) Are you still unable to work because of your illnesses, injuries, or conditions? →	☑ Yes — Go to item 26 ☐ No — Go to (b)
	(b) Enter the date you became able to work. →	MONTH, DAY, YEAR 9,500

IMPORTANT INFORMATION ABOUT DISABILITY INSURANCE BENEFITS
PLEASE READ CAREFULLY

SUBMITTING MEDICAL EVIDENCE: I understand that I must provide medical evidence about my disability and I may be asked to assist the Social Security Administration in obtaining the evidence. I understand that I may be requested by the State Disability Determination Services to have a consultative examination at the expense of the Social Security Administration and that if I do not go, my claim may be denied.

26.	Are your illnesses, injuries, or conditions related to your work in any way? →	☐ Yes ☑ No
27.	(a) Have you filed, or do you intend to file, for any other public disability benefits (including workers' compensation, Black Lung benefits and SSI)? →	☑ Yes — Go to(b) ☐ No — Go to item 28
	(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 (SSI) ☐ Other (If "Other," complete a Workers' Compensation/Public Disability Benefit Questionnaire)	
28.	(a) Did you receive any money from an employer(s) on or after the date in item 10 when you became unable to work because of your illnesses, injuries, or conditions? If "Yes", give the amounts and explain in "Remarks". →	☐ Yes ☑ No Amount $ _____
	(b) 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". →	☑ Yes ☐ No Amount $ 500.00
29.	Do you, or did you, have a child under age 3 (your own or your spouse's) living with you in one or more calendar years when you had no earnings?	☐ Yes ☑ No
30.	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 the parent's name and address and Social Security number, if known, in "Remarks".	☐ Yes ☑ No
31.	If you were unable to work before age 22 because of an illness, injury or condition, do you have a parent (including adoptive or stepparent) or grandparent who is receiving social security retirement or disability benefits or who is deceased? If yes, enter the name(s) and Social Security number, if known, in "Remarks" (if unknown, write "Unknown").	
32.	Do you have any unsatisfied felony warrants for your arrest? →	☐ Yes ☑ No
33.	Do you have any unsatisfied Federal or State warrants for your arrest for violating the conditions of your probation or parole? →	☐ Yes ☑ No

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

Item 28. The money was sick pay; there will be no more. Also, I request that my treating doctor's opinion be obtained about my ability to perform activities before a decision is made on my claim.

Also, I request that only a licensed doctor make any determinations about the medical severity of my disorders in regard to whether I am disabled. I ask to be informed before SSA makes any denial determination, if a doctor has not reviewed my claim, or if the SSA has not contacted my treating doctor for an opinion. I feel I have a right to have my medical records be reviewed by a real doctor, and not merely a disability examiner, and that my treating doctor's opinion be considered.

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

SIGNATURE OF APPLICANT	Date (Month, Day, Year) 10-12-2011
Signature (First name, middle initial, last name) (Write in ink) SIGN HERE ▶	Telephone Number(s) at which you may be contacted during the day. (Include the area code) 310-555-1111

FOR OFFICIAL USE ONLY	Direct Deposit Payment Address *(Financial Institution)*			
	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.)*
P.O. Box 24830

City and State	ZIP Code	County *(if any)* in which you now live
Los Angeles CA	90025	

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)*

FOR YOUR INFORMATION

An agency in your State that works with us in administering the Social Security disability program is responsible for making the disability decision on your claim. In some cases, it is necessary for them to get additional information about your condition or to arrange for you to have a medical examination at Government expense.

Collection and Use of Information From Your Application — Privacy Act Notice/Paperwork Act Notice

The Social Security Administration is authorized to collect the information requested on this form under sections 202, 205, and 223 of the Social Security Act. The information you provide will be used by the Social Security Administration to determine if you or a dependent is eligible to insurance coverage and/or monthly benefits. You do not have to give us the requested information. However, if you do not provide the information, we will be unable to make an accurate and timely decision concerning your entitlement or a dependent's entitlement to benefit payments.

The information you provide may be disclosed to another Federal, State, or local government agency for determining eligibility for a government benefit or program, to a Congressional office requesting information on your behalf, to an independent party for performance of research and statistical activities, or to the Department of Justice for use in representing the Federal government.

We may also use this information 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.

PAPERWORK REDUCTION ACT

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 control number. We estimate that it will take about 20 minutes to read the instructions, gather the facts, and answer the questions. **SEND THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. The office is listed under U. S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213.** *You may send comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore MD 21235-6401.* ***Send only comments relating to our time estimate to this address, not the completed form.***

RECEIPT FOR YOUR CLAIM FOR SOCIAL SECURITY DISABILITY INSURANCE BENEFITS

PERSON TO CONTACT ABOUT YOUR CLAIM	SSA OFFICE	DATE CLAIM RECEIVED
TELEPHONE NUMBER (INCLUDE AREA CODE)		

Your application for Social Security disability benefits has been received and will be processed as quickly as possible.

You should hear from us within _____ days after you have given us all the information we requested. Some claims may take longer if additional information is needed.

In the meantime, if you change your address, or if there is some other change that may affect your claim, you — or someone for you — should report the change. The changes to be reported are listed below.

Always give us your claim number when writing or telephoning about your claim.

If you have any questions about your claim, we will be glad to help you.

CLAIMANT	SOCIAL SECURITY CLAIM NUMBER

CHANGES TO BE REPORTED AND HOW TO REPORT
FAILURE TO REPORT MAY RESULT IN OVERPAYMENTS THAT MUST BE REPAID

- You change your mailing address for checks or residence. *To avoid delay in receipt of checks you should ALSO file a regular change of address notice with your post office.*
- Your citizenship or immigration status changes.
- You go outside the U.S.A. for 30 consecutive days or longer.
- Any beneficiary dies or becomes unable to handle benefits.
- Custody Change—Report if a person for whom you are filing or who is in your care dies, leaves your care or custody, or changes address.
- You are confined to jail, prison, penal institution or correctional facility for conviction of a crime or you are confined to a public institution by court order in connection with a crime.
- You become entitled to a pension or annuity based on your employment after 1956 not covered by Social Security, or if such pension or annuity stops.
- Your stepchild is entitled to benefits on your record and you and the stepchild's parent divorce. Stepchild benefits are not payable beginning with the month after the month the divorce becomes final.
- You have an unsatisfied warrant for your arrest for a crime or attempted crime that is a felony (or, in jurisdictions that do not define crimes as felonies, a crime that is punishable by death or imprisonment for a term exceeding 1 year).
- You have an unsatisfied warrant for a violation of probation or parole under Federal or State law.
- Change of Marital Status—Marriage, divorce, annulment of marriage. You must report marriage even if you believe that an exception applies.
- You return to work (as an employee or self-employed) regardless of amount of earnings.
- Your condition improves.
- You are under age 65 and you apply for or begin to receive workers' compensation (including black lung benefits) or another public disability benefit, or the amount of your present workers' compensation or public disability benefit changes or stop, or you receive a lump-sum settlement

HOW TO REPORT

You can make your reports by telephone, mail, or in person, whichever you prefer.

If you are awarded benefits, and one or more of the above change(s) occur, you should report by:

- Calling us TOLL FREE at 1-800-772-1213.
- If you are deaf or hearing impaired, calling us TOLL FREE at TTY 1-800-325-0778; or
- Calling, visiting or writing your local Social Security office at the phone number and address above.

For general information about Social Security, visit our web site at www.socialsecurity.gov.