STATEMENT REGARDING CONTRIBUTIONS

All items on this form requiring an answer must be answered or marked "Unknown."

PRIVACY ACT/PAPERWORK ACT NOTICE: This notice is given pursuant to the Privacy Act of 1974 (5 U.S.C. 552a). The information requested on this form is sought pursuant to the authority granted in Sections 202(d) and (h) of the Social Security Act. The information provided will be used to confirm entitlement to such benefits. Other uses which may be made of the information are summarized below. While completion of this form is voluntary, failure to provide all or any part of the requested information may be cause for denial of benefits. The information you furnish on this form may be disclosed by Social Security to another person or to another governmental agency as follows for the following purposes: (1) to assist Social Security in establishing the right of an individual to Social Security benefits; (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 Federal laws requiring the exchange of information between Social Security and another agency.
Computer Matching: 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.
Explanation 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 your 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 15 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.

PRINT NAME OF WAGE EARNER OR SELF-EMPLOYED PERSON	ENTER SOCIAL SECURITY NUMBER
	___ ___ ___ - ___ ___ - ___ ___ ___ ___

I understand that information given by me will be used in connection with an application for insurance benefits payable under the provisions of Title II of the Social Security Act, as amended, on the record of the wage earner or self-employed person named above.

PRINT YOUR FULL NAME (FIRST NAME, MIDDLE INITIAL, LAST NAME)	RELATIONSHIP TO CLAIMANT
PRINT NAME OF CLAIMANT	RELATIONSHIP TO WAGE EARNER OR SELF-EMPLOYED PERSON

1. (a) Give the following information (for the period indicated below) about each person or agency who contributed to the claimant's support.

FROM	TO

NAME AND ADDRESS OF CONTRIBUTORS	RELATIONSHIP TO CLAIMANT	CONTRIBUTIONS BEGAN		CONTRIBUTIONS ENDED		HOW OFTEN MADE *(Weekly, monthly or occasionally)*	AVERAGE AMOUNT OF CONTRIBUTION
		MO.	YR.	MO.	YR.		
							$
							$
							$

(b) Was there any break in contributions by any contributor within the period? ☐ YES ☐ NO
If "Yes," give name of contributor, months in which no contributions were made, and reason:

(c) If any contributions ended before the wage earner's or self-employed person's death or, if living, before application was filed, give name of contributor and why he stopped:

(d) If other than cash was contributed, such as clothing, board or room, give the following information regarding items supplied during the period in 1(a).

NAME OF CONTRIBUTOR	ITEMS CONTRIBUTED	APPROXIMATE VALUE
		$
		$

(e) Give name and address of person or agency to which payments were made for claimant's support:

2. Did the claimant have wages or income of his or her own? ☐ Yes ☐ No

If "Yes, " how much per month? $ ________________

IN WHICH MONTHS (Specify)

3. (a) Is claimant a child who lived with more than one parent (natural, adopting or stepparent)?
☐ Yes *If "Yes" answer (b), (c) and (d) below.* ☐ No *If "No" go on to item 4.*

(b) If both parents with whom child lived contributed to child's support, did they use their monies as one household fund? ☐ Yes ☐ No

If "Yes," how much did each contribute to the fund?	MOTHER $	FATHER $

(c) If their monies were not combined, what understanding did they have as to how much each would contribute to the child's support?

NOTE: If such agreement was in writing, submit a copy.

(d) What was the monthly income of each?	MOTHER $	FATHER $

4. How did you learn of the facts you gave in questions 1, 2, and 3?

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 PERSON MAKING STATEMENT

SIGNATURE (*First name, middle initial, last name*) *(Write in ink)*

SIGN HERE ▶

DATE *(Month, day, year)*

TELEPHONE NUMBER *(Including Area Code)*

MAILING ADDRESS (Number and street, Apt. No., P.O. Box, or Rural Route)

CITY AND STATE	ZIP CODE	Enter Name of County (if any) in which you now live

Witnesses are required ONLY if this statement has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the person making the statement must sign below, giving their full addresses.

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)*