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(DO NOT WRITE

APPLICATI (PAYABLE UNDER ⁻		IN THIS SPACE) VA DATE STAMP				
IMPORTANT Read instructions b instruction sheet	efore completing form.	Detach and r	etain ONLY the			
1. FIRST NAME - MIDDLE NAME · (Type or print)	LAST NAME OF VETE	ERAN	2. DATE OF DE	ATH		
NOTE: If the veteran's Social Secu	rity No. is unknown, cor	mplete Items	4, 5, 6, and 7 about	veteran		
3. SOCIAL SECURITY NO. OF VETERAN	4. DATE OF BIRTH	5. PLACE C	5. PLACE OF BIRTH			
6. NAME OF FATHER	7. MAIDEN NAME OF	MOTHER		ANY TI	ORK IN THE RAILROAD ME AFTER 1936?	
NOTE: The following information reserves) after September 7, 193 Public Health Service or the Nati Allied country military service. If	9, in the military service onal Oceanic and Atm	ce of the Un ospheric Ad	iod of the veteran's ited States or servi Iministration or du	active ce as a ring WV	service (regular or commissioned officer in the	
9A. DATE ENTERED ACTIVE SERVICE	9B. SERVICE NO.	PRVICE NO. 9C. DATE SEPARATED 9D. FROM ACTIVE SERVICE		OR	D. GRADE, RANK, OR RATING, ORGANIZATION AND BRANCH OF SERVICE	
10. RELATIONSHIP OF APPLICANT TO VETERAN SURVIVING SPOUSE OR SURVIVING DIVORCED SPOUSE CHILD PAR			11. DATE OF BIRTH APPLICANT	DATE OF BIRTH OF 12. VA FILE NAPPLICANT		
CHILDREN: Show names of survey grandchildren (including stepgrate) 18; (b) age 18 to 19 and attending before age 22).	ndchildren) who at an	y time since	e the veteran died, v	were ur	nmarried and (a) under age	
13A.			13B.			
13C.		13D.				
I know that anyone who ma application or for use in determing Federal law by fine, impris	ning a right to paymer	nt under the	Social Security Act	comm	its a crime punishable under	
14. DATE (MM/DD/YYYY) 15. SIG	NATURE OF APPLICA	NT (First nai	me, middle initial, las	t name)	(Sign in ink)	
16. MAILING ADDRESS OF APPL	ICANT (No. and street	or rural route	e, city or P.O., State	and	17. TELEPHONE NO. (Include Area Code)	

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WITNESSE	ES REQUIRED ONLY IF SIGN	NATURE OF APPLICANT IS MADE BY '	"X" MARK ABOVE			
18A. SIGNATURE OF WITNESS		18B. ADDRESS OF WITNESS ZIP Code)	18B. ADDRESS OF WITNESS (No. and street, city, State and ZIP Code)			
19A. SIGNATURE OF WITNESS		19B. ADDRESS OF WITNESS ZIP Code)	19B. ADDRESS OF WITNESS (No. and street, city, State and ZIP Code)			
ITEMS BELOW TO	BE COMPLETED BY THE DE	EPARTMENT OF VETERANS AFFAIRS	Use reverse for "Remarks"			
20. PROOFS RECEIVED DEATH MARRIAGE AGE OTHER (Specif	(NAME)	21. PROOFS REQUESTED FI (Specify) DEATH MARRIAGE AGE OTHER (Specify)	(NAME) (NAME) (NAME)			
_	NT: PLEASE READ THE F	OF TRANSMITTING VA OFFICE OLLOWING BEFORE YOU COMPLI RM SSA-24, APPLICATION FOR SU				

This application form, SSA-24, is an Application for Survivors Benefits Payable under Title II of the Social Security Act, as amended. Under authority of section 202(o) of the Social Security Act, the application requests information in order to determine eligibility to social security benefits. You do not have to complete this application; there are no penalties under the law if you do not complete part or all of the SSA-24. However, it is usually to your advantage to provide the information because not providing it could prevent an accurate and timely decision on your claim or could result in the loss of some benefits or insurance coverage.

If you do wish to supply the information requested on the SSA-24, this information will be forwarded to the Social Security Administration and used by them to determine whether social security benefits may be payable to surviving dependent(s) of the veteran. Social Security will then contact you regarding any social security benefits payable based on information given on this form.

If you should have any question about entitlement to social security benefits or the information you have provided on this form, please contact your local social security office.

Complete each item of the attached application, Form SSA-24, (except Items 20 through 23). When signed and dated the form SHOULD BE LEFT ATTACHED to your completed

- VA FORM 21-534, Application for Dependency and Indemnity Compensation,
 Death Pension and Accrued Benefits by a Surviving Spouse or Child (Including Death Compensation if Applicable) or
- VA FORM 21-535, Application for Dependency and Indemnity Compensation by Parent(s) (Including Accrued Benefits and Death Compensation When Applicable).

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Privacy Act Statement Collection and Use of Personal Information

Section 202(o) of the Social Security Act, as amended, allows us to collect this information. Furnishing us this information is voluntary. However, failing to provide all or part of the information may prevent us from making an accurate and timely decision on your request for benefits.

We will use the information to determine your eligibility for benefits. We may also share this information for the following purposes, called routine uses:

- To Federal, State, or local agencies (or agents on their behalf), for administering income or health maintenance programs including programs under the Social Security Act; and
- To contractors and other Federal Agencies, as necessary, for the purpose of assisting us in the
 efficient administration of our programs.

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 (SORN) 60-0089, entitled Claims Folders System, as published in the Federal Register (FR) on October 31, 2019, at 84 FR 58422; and 60-0090, entitled Master Beneficiary Record, as published in the FR on January 11, 2006, at 71 FR 1826. Additional information, and a full listing of all of 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 <u>Paperwork Reduction Act of 1995</u>. 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 15 minutes to read the instructions, gather the facts, and answer the questions. **Send <u>only</u> 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.