STATEMENT REGARDING MARRIAGE

All questions must be answered or marked "Unknown." If you need more space for answers, continue them under "Remarks" on reverse side.

Print Name of Wage Earner or Self-Employed Person *(Herein referred to as the "Worker".)*	Enter Worker's Social Security Number

Print Name of Applicant

I understand that this statement will be considered in connection with an application by the applicant named above for payment of benefits under the provisions of Title II of the Social Security Act, as amended, based on the earnings of the Worker named above.

Print Your Full Name *(First name, middle initial, last name)*

1. What is your relationship to the Worker? *(Mother, child, cousin, etc. - if not related, state "None.")*

   To the Applicant? *(Mother, child, cousin, etc. - if not related, state "None.")*

2. How long have you known the Worker? The Applicant?

3. How often and on what occasions did you meet the Worker?

   The Applicant?

4. To your knowledge, were (are) the Worker and Applicant generally known as a married couple? ☐ Yes ☐ No

5. Did (do) you consider them married couple? ☐ Yes ☐ No

   Give facts and explain fully the reasons for your belief:

6. Did you hear them refer to each other as a spouse? ☐ Yes ☐ No

   If "Yes," when and where?

7. In your opinion, did (do) they maintain a home and live together as a married couple? ☐ Yes ☐ No
If "Yes," where and when?

CITY OR TOWN	STATE	DATES	
		FROM	TO

8. To your knowledge, did they live together continuously? ☐ Yes ☐ No
If "No," explain.

9. To your knowledge, has either the Worker or the Applicant entered into any other marriage? ☐ Yes ☐ No
If "Yes, " give the following information regarding all such marriages.

STATE WHETHER WORKER OR APPLICANT	TO WHOM MARRIED	DATE AND PLACE OF MARRIAGE	HOW MARRIAGE TERMINATED	DATE AND PLACE MARRIAGE TERMINATED

Remarks: *(This space may be used for explaining any answers to the questions. If you need more space, attach a separate sheet.)*

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 OF PERSON MAKING STATEMENT

Signature *(First name, middle initial, last name) (Write in ink)*	Date *(MM/DD/YYYY)*
	Telephone Number (include Area Code)

Mailing Address *(Number and Street, Apt. No., P.O. Box, or Rural Route)*

City and State	ZIP Code

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)*

Privacy Act Statement
Collection and Use of Personal Information

Section 216(h)(1)(A) 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 an accurate and timely decision on the applicant's claim.

We will use the information you provide to establish marital relationship and determine benefits eligibility. We may also share the information for the following purposes, called routine uses:

- To contractors and other Federal agencies, as necessary, for the purpose of assisting SSA in the efficient administration of our programs; and

- To student volunteers, individuals working under a personal services contract, and other workers who technically do not have the status of Federal employees, when they are performing work for SSA, as authorized by law, and they need access to personally identifiable information in SSA records in order to perform their assigned agency functions.

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 60-0320, Electronic Disability Claim File, as published in the FR on June 4, 2020, at 85 FR 34477. Additional information, and a full listing of all of our SORNs, is available on our website at www.socialsecurity.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 control number. We estimate that it will take about 60 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. You can find your local Social Security office through SSA's website at www.socialsecurity.gov. Offices are also listed under U. S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213 (TTY 1-800-325-0778).** *You may send 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.* ***Send only comments relating to our time estimate to this address, not the completed form.***