



Republic of Palau
SOCIAL SECURITY ADMINISTRATION

Date Received/Logged:
Date Filed/Complete:
Telephone Number:

APPLICATION FOR SURVIVOR DISABLED CHILD INSURANCE BENEFITS

I hereby apply for all insurance benefits payable to me under the Social Security Act, as amended.

1. Child's Social Security Number [Grid for SSN]
First Middle Last

2. Child's Full Name

3. Child's Date of Birth: [Month/Day/Year] 4. Child's relationship to the deceased

5. Applicant's Full Name: 6. Social Security Number

7. Address: Phone:

Current Residence:

City and State: Zip Code:

8. Applicant's Date of Birth [Month/Day/Year] 9. Citizenship:

10. Your relationship to the child:

11. Did the child live with the deceased at the time of death? Yes No

12. Does the child live with you? Yes No If No, with whom does the child live?

13. Describe (in detail) the nature of the child's disability:

14. What month, day and year did you realize the child's disability condition?

15. I authorize any physician or hospital to disclose to Social Security any medical records or other information about the child's disability.

16. Does (did) the child have earnings? Yes, if yes when Amount of Earnings \$ No

17. How your earnings affect your benefits: The child may earn up to \$1,800.00 per quarter and still receive all his/her survivor benefits. If he/she earn over that amount, \$1.00 in benefits will be reduced for each \$3.00 of earnings over \$1,800.00 per quarter.

DECEASED WAGE EARNER (question 18 to 26)

18. Social Security Number: [] [] [] [] [] [] [] [] [] []
First Middle Last

19. Full Name: _____

20. Sex: Male ___ Female ___ 21. Date of Birth / / 22. Citizenship: _____
Month Day Year

23. Date of Death / / 24. Place of Death _____
Month Day Year

25. Cause of Death
(a) Primary: _____ (b) Secondary: _____

26. Was the deceased wage earner ever entitled to Social Security Benefits? Yes No

27. If yes, what kind of benefits? Disability Retirement

28. I understand that all payments made to me on behalf of a child must be spent for the child's present needs, or, if not presently needed, saved for the child's future needs, and I do agree to use the benefits that way.

29. I agree to notify Social Security promptly if any of the following occur and to promptly return any benefit check I receive which is not due:
a. A Child is adopted or there is a change in custody/Guardianship
b. A disabled child's condition improves
c. A child goes to work, gets married, or dies
d. Change of Address
e. Change of Child's Citizenship

Signature: *I know that anyone who makes or causes to be made a false statement or representation of material fact in an application for use in determining a right to payment under the Social Security Act commits a crime punishable by fine, imprisonment or both. I acknowledge my agreement to the statements in No. 15, No.28 & No.29 and affirm that all information I have given in this document and any attachments are true and correct.*

SIGN HERE: _____ DATE: _____
(Note: This application must be notarized if not signed in the presence of a Social Security Administration Representative).

Direct Deposit: If you want your payments sent directly to the bank, check here: *If checked, please provide a copy of your bank account or a bank statement.*
Your Bank's Name & Address _____
Your Bank's ABA Number _____
Your Bank's Account Number _____ Account Type: _____

Witness: Required ONLY if this application has been signed by (X). Two witnesses to the signing who know the applicant must sign below, giving their full address.
Sign Here: _____ Sign Here: _____
(Print Name and Sign) (Print Name and Sign)
Address: _____ Address: _____

- Note: This application will not be processed without the following documents:**
1. Death Certificate of Wage Earner
 2. Birth Certificate of Child
 3. Applicant Picture Identification
 4. Proof for child dependency if not the natural child or not adopted through Court.
 5. Proof of Guardianship if the applicant is living with someone other than the surviving spouse of the decedent.