SOCIAL SECURITY ADMINISTRATION

TOE 210

Form Approved
OMB No. 0960-0398

(Do not write in this space)

CERTIFICATE OF ELECTION FOR REDUCED SPOUSE'S BENEFITS

1. PRINT NAME OF WAGE EARNER OR SELF-EMPLOYED PERSON *(Hereafter called "Worker")*	ENTER HIS OR HER SOCIAL SECURITY NUMBER ___ | __ | ____
2. PRINT YOUR FULL NAME *(First name, middle initial, last name)*	ENTER YOUR SOCIAL SECURITY NUMBER *(If "none" or "unknown" so indicate.)* ___ | __ | ____

A spouse's insurance benefit may be payable for months between age 62 and full retirement age (FRA), even if you do not have in your care a child of the worker under age 16 or disabled entitled to a child's insurance benefit. Choosing to receive spouse's insurance benefits before FRA will result in a permanent reduction in your monthly benefits. Since such benefit will be at a permanently reduced rate and will continue at a permanently reduced rate even after FRA, the law requires that we obtain a certificate of election if you wish to receive the permanently reduced benefit. The amount of the reduction is 25/36 of 1 percent for each of the first 36 months from the start of the permanently reduced benefits to, but not including, the month you reach FRA. The reduction is 5/12 of 1 percent for each such month in excess of 36. In addition, if another beneficiary(ies) other than the wage earner (e.g., a student child beneficiary) is entitled to a monthly benefit on this Social Security number, election for a reduced spouse's benefit may cause a reduction in total monthly benefits. These reduced benefits may be paid for as many as 12 months before the month this certificate is filed. No reduced spouse's benefit may begin before the month you are 62. If you are eligible for retirement insurance benefits in the month this certificate takes effect, you will be considered to have applied for them.

3.	I elect to accept permanently reduced benefits as provided in Section 202(q) of the Social Security Act, beginning with	***(Month)*** ***(Year)***
4.	Did you work in the railroad industry for 5 years or more? ☐ Yes ☐ No	

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 COMPLETING THIS CERTIFICATE

Signature *(First name, middle initial, last name) (Write in ink)* SIGN HERE ▶	Date *(Month, day, year)* Telephone Number (include 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 certificate has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the person completing this certificate 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 202q(5)(A) of the Social Security Act (42 U.S.C. 402q(5)(A)), as amended, authorizes us to collect this information. The information you provide will be used to determine whether you may be eligible to receive reduced benefits as a spouse.

The information you furnish on this form is voluntary. However, failure to provide the requested information may prevent us from making a determination regarding payment of reduced benefits.

We rarely use the information you supply for any purpose other than for making a determination relating to approval for reduced benefits. However, we may use it for the administration and integrity of Social Security programs. We may also disclose information to another person or to another agency in accordance with approved routine uses, which include but are not limited to the following:

1. To enable a third party or an agency to assist Social Security in establishing rights to Social Security benefits and/or coverage;
2. To comply with Federal laws requiring the release of information from Social Security records (e.g., to the Government Accountability Office and Department of Veterans' Affairs);
3. To make determinations for eligibility in similar health and income maintenance programs at the Federal, state, and local level; and
4. To facilitate statistical research and audit activities necessary to assure the integrity and improvement of Social Security programs (e.g., to the Bureau of the Census and private concerns under contract to Social Security).

We may also use the information you provide in computer matching programs. Matching programs compare our records with records kept by other Federal, state, or local government agencies. Information from these matching programs can be used to establish or verify a person's eligibility for Federally funded or administered benefit programs and for repayment of payments or delinquent debts under these programs.

Additional information regarding this form, routine uses of information, and our programs and systems, is available on-line at www.socialsecurity.gov or at your local Social Security office.

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 2 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING 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 (TTY 1-800-325-0778).** 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.***