AUTHORIZATION TO CEASE ALLOTMENT

FSM SOCIAL SECURITY ADMINISTRATION

FSMSS-113b Rev. 9/2004

Beneficiary Name: _____ Date: _____

Address line 1: _____
Address line 2: _____
Address line 3: _____ Zip Code: _____

I WOULD LIKE TO REQUEST THAT ANY AMOUNT OF MY SS MONTHLY BENEFIT CHECK MADE PAYABLE TO

Allottee/Org.: _____
Address: _____ Zip Code: _____
Name of Acct.: _____

BE CEASED IMMEDIATELY UPON RECEIPT OF THIS FORM.

Reason for request: _____
_____

Beneficiary's Signature: _____ ID. # (if any): _____
Witnessed by (FSMSSA Staff): _____ Date: _____

DO NOT WRITE BELOW – FOR FSMSS USE ONLY

TYPE OF BENEFIT: ☐ RE ☐ SS ☐ DI BE SS NO. _____ WE SS NO. _____	CLAIM DIVISION ALLOTTEE CODE _____ VERIFIED BY: _____ _____ EFFECTIVE DATE

APPROVED BY:

_____ _____
Alexander R. Narruhn, Administrator Date

FSMSS is not liable for any delayed and/or late payments, charged interest, etc. that may have incurred due to computer technicalities if any.