



QUESTIONNAIRE

Dear Beneficiary:

Please complete this survey and submit it to our office as soon as possible. Failure to do so will result in benefit withholding.
Thank you.

<input type="checkbox"/> Retirement	<input type="checkbox"/> Disability	<input type="checkbox"/> Surviving Spouse or <input type="checkbox"/> Guardian (skip to item 4)
1. Are you working now? <input type="checkbox"/> yes <input type="checkbox"/> no If yes, since when? _____ Date	1. Are you working now? <input type="checkbox"/> yes <input type="checkbox"/> no If yes, since when? _____ Date 2. Has your condition improved? <input type="checkbox"/> yes <input type="checkbox"/> no	1. Are you working ? <input type="checkbox"/> yes <input type="checkbox"/> no If yes, since when? _____ Date 2. Have you remarried? <input type="checkbox"/> yes <input type="checkbox"/> no 3. Do you have children receiving social security benefits? <input type="checkbox"/> yes <input type="checkbox"/> no 4. Are any of the children receiving social security benefits married? <input type="checkbox"/> yes <input type="checkbox"/> no working? <input type="checkbox"/> yes <input type="checkbox"/> no adopted? <input type="checkbox"/> yes <input type="checkbox"/> no no longer live with you? <input type="checkbox"/> yes <input type="checkbox"/> no _____ name of child _____ ss number _____ died? <input type="checkbox"/> yes <input type="checkbox"/> no _____ name of child _____ ss number _____ _____ Wage Earner's Name
<p>This section for all. Do not leave blank.</p> Retiree, disability recipient, or surviving spouse died? <input type="checkbox"/> yes <input type="checkbox"/> no Who died? _____ (print name) _____ (ss #) _____ (when?)		

IMPORTANT:

- This survey form must be notarized if not signed in the presence of a representative of the FSMSSA.
- If you are living abroad and employed, please submit along with this survey form copies of W-2 forms for all years you have been employed.

BENEFICIARY'S DECLARATION

I understand that any false statement or misrepresentation of any fact in maintaining a right for benefits is a crime punishable under Title 53 of the FSM Code.

Beneficiary's Printed Name: _____

Signature: _____

Authorized Representative: _____

(attach authorization slip)

Relationship to Beneficiary: _____

Signature: _____

Date: _____

Beneficiary Current Address: _____

How long have you been at this address?

Telephone No.: _____

Cell Phone No.: _____

Municipality: _____

Interviewer: _____