# Application for Social Security Insurance Benefits

**Federated States of Micronesia**

**Social Security Administration**

**Headquarters:** P.O. Box L
Kolonia, Pohnpei State FM 96941

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**Application for Social Security Insurance Benefits**

**FSMSS-101**
Revised 8/2004

### Part I

**Applicant Information**

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

<table>
<thead>
<tr>
<th>3. Applicant's SS Number</th>
<th>4. Applicant's Full Name</th>
<th>5. Name Used at Birth</th>
<th>6. Other Names Used</th>
<th>7. Date of Birth</th>
<th>8. Present Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] Male</td>
<td>[ ] Female</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

### FOR OFFICE USE ONLY

<table>
<thead>
<tr>
<th>Claim Number</th>
<th>Date Filed (At Branch)</th>
<th>Date Received At HQ</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ]- [ ]- [ ]</td>
<td>[ ]- [ ]- [ ]- [ ]- [ ]</td>
<td>[ ]- [ ]- [ ]- [ ]</td>
</tr>
</tbody>
</table>

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### 1. Have you ever filed an application for Social Security benefits?

- [ ] Yes
- [ ] No

### 2. If yes, what kind of application did you file?

- [ ] Retirement
- [ ] Disability
- [ ] Survivor

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### 12. Information on Your Last Employment

- **A. Employer Name:**
- **B. Address or Place of Business:**
- **C. Date You Were Last Employed:**

### 13. Are You Employed?

- [ ] Yes
- [ ] No

- **A. If Yes, How Much Is Your Present Salary:**

### 14. Current Employer (If Applicable)

- **A. Employer Name:**
- **B. Address or Place of Business:**
- **B. Employer ID No:**

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### 16. Marital Status

- [ ] Married
- [ ] Single
- [ ] Widowed, Date [ ]- [ ]- [ ]
- [ ] Divorced, Date [ ]- [ ]- [ ]

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### 17. Spouse's Name

<table>
<thead>
<tr>
<th>First Name</th>
<th>Maiden Name</th>
</tr>
</thead>
</table>

### 18. Spouse's SS Number

- [ ]- [ ]- [ ]

### 19. Spouse's Date of Birth

- [ ]- [ ]- [ ]

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### 20. Date of Marriage

### 21. Place of Marriage

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### 22. Were You Married Before?

- [ ] Yes
- [ ] No

### 23. If Yes, Enter the Following Information About Your Previous Marriage:

**To Whom Married**

**When**

**Where**

**How Marriage Ended:**

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For Office Use Only

**Claim Number**

**Date Filed (At Branch)**

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PART II
DISABILITY BENEFIT APPLICANTS ONLY

24. DESCRIBE IN DETAIL THE NATURE OF YOUR DISABILITY.

25. WHAT MONTH, DAY AND YEAR DID YOU BECOME UNABLE TO WORK BECAUSE OF YOUR DISABILITY?

26. ARE YOU STILL DISABLED?

- [ ] YES
- [ ] NO

27. IF NO, ENTER THE DATE YOU WERE ABLE TO RETURN TO WORK.

<table>
<thead>
<tr>
<th>MONTH</th>
<th>DAY</th>
<th>YEAR</th>
</tr>
</thead>
</table>

28. HAVE YOU RECEIVED OR DO YOU EXPECT TO RECEIVE ANY KIND OF WORKER’S COMPENSATION BENEFIT? IF YES, GIVE DETAILS.

- [ ] NO
- [ ] YES

29. DID YOU RECEIVE ANY MONEY FROM YOUR EMPLOYER(S) ON OR AFTER THE DATE YOU SAID YOU BECAME UNABLE TO WORK BECAUSE OF YOUR DISABILITY? IF YES, GIVE AMOUNTS AND EXPLAIN.

- [ ] NO
- [ ] YES

- [ ]
- [ ]
- [ ]
- [ ]
- [ ]
- [ ]
PART III
AUTHORIZATION TO OBTAIN INFORMATION

DO YOU AUTHORIZE SOCIAL SECURITY OFFICE TO OBTAIN FROM YOUR EMPLOYER □ YES □ NO INFORMATION NEEDED TO PROCESS YOUR APPLICATION FOR BENEFITS?

DO YOU AUTHORIZE ANY PHYSICIAN OR HOSPITAL TO DISCLOSE TO SOCIAL SECURITY □ YES □ NO ANY MEDICAL RECORDS OR OTHER INFORMATION ABOUT YOUR DISABILITY?

SIGNATURE OF APPLICANT:___________________________ DATE:_____________________

PART IV
APPLICANT’S STATEMENT

I AGREE TO NOTIFY SOCIAL SECURITY IF ANY OF THE FOLLOWING OCCURRED AND TO PROMPTLY RETURN ANY BENEFIT CHECK I RECEIVE WHICH IS NOT DUE:

1. I RETURN TO WORK OR BECOME SELF-EMPLOYED.
2. MY MEDICAL CONDITION IMPROVES (if disability beneficiary).
3. I APPLY FOR OR CURRENTLY RECEIVE ANY KIND OF WORKER’S COMPENSATION.

I CERTIFY THAT INFORMATION GIVEN HEREIN ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

I AUTHORIZE INVESTIGATION OF ALL STATEMENTS CONTAINED IN THIS APPLICATION AS MAY BE NECESSARY IN DETERMINING A RIGHT TO BENEFIT PAYMENT.

I UNDERSTAND THAT FALSE OR MISLEADING INFORMATION GIVEN IN MY APPLICATION OR INTERVIEW(S) CONSTITUTES A CRIME PUNISHABLE BY FINE, IMPRISONMENT, OR BOTH.

SIGNATURE OF APPLICANT:___________________________ DATE:_____________________

WITNESSES: AT LEAST TWO WITNESSES ARE REQUIRED IF APPLICANT SIGNED (X).

___________________________________________________________
(Print Name and Sign) _______________________________ DATE

ADDRESS:________________________________________________

___________________________________________________________
(Print Name and Sign) _______________________________ DATE

ADDRESS:________________________________________________

___________________________________________________________
ADDRESS:________________________________________________

___________________________________________________________
ADDRESS:________________________________________________

IF YOU QUALIFIED FOR BENEFITS, GIVE ADDRESS WHERE YOU WANT YOUR BENEFITS TO BE SENT:

___________________________________________________________

___________________________________________________________

___________________________________________________________

___________________________________________________________

(IF DIRECT DEPOSIT, GIVE YOUR BANK ACCOUNT NUMBER:___________________________ )

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DOCUMENTS REQUIRED TO ACCOMPANY THIS APPLICATION:

☐ RETIREMENT APPLICATION

1. *Birth documents* - you must submit at least two (2) documents to support your date of birth which were executed at least five (5) years prior to your 60th birthday. This may include a passport, medical record, municipal village record, baptismal record, marriage record, child’s birth certificate, driver’s license, employment record, etc.

2. *Employment Termination paper*

☐ DISABILITY APPLICATION

1. *Birth documents* - you must submit at least two (2) documents to support your date of birth which were executed at least five (5) years prior to your 60th birthday. This may include a passport, medical record, municipal village record, baptismal record, marriage record, child’s birth certificate, driver’s license, employment record, etc.

2. *Employment Termination paper*

3. *Medical Records Request*

4. *Medical Records Release*

5. *Disability Report Form*

*Additional information or documents may be required of the applicant.*

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**FSM SOCIAL SECURITY OFFICES**

YAP BRANCH
P.O. Box 479
Colonia, Yap FM 96943
Phone No.: (691)350-2309
Fax No.: (691)350-4290

POHNPEI BRANCH
P.O. Box L
Kolonia, Pohnpei FM 96941
Phone No.: (691)320-2709/2181
Fax No.: (691)320-8963

CHUUK BRANCH
P.O. Box 397
Weno, Chuuk FM 96942
Phone No.: (691)330-2200
Fax No.: (691)330-2647

KOSRAE BRANCH
P.O. Box 435
Tofol, Kosrae FM 96944
Phone No.: (691)370-3048
Fax No.: (691)370-3790

*Applicant should submit this application for benefits in his/her respective state. If applying from outside of the FSM, send your application to the state where you worked last.*