FEDERATED STATES OF MICRONESIA
SOCIAL SECURITY ADMINISTRATION

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

APPLICATION FOR SOCIAL SECURITY INSURANCE BENEFITS

FSMSS-101
Revised 8/2004

☐ **RETIREMENT** ☐ **DISABILITY**

FOR OFFICE USE ONLY	**1. HAVE YOU EVER FILED AN APPLICATION FOR SOCIAL SECURITY BENEFITS?**	**2. IF YES, WHAT KIND OF APPLICATION DID YOU FILE?**
CLAIM NUMBER ☐☐-☐☐-☐☐☐☐	☐ YES ☐ NO	☐ RETIREMENT ☐ DISABILITY ☐ SURVIVOR
DATE FILED (AT BRANCH)		
DATE RECEIVED AT HQ		

PART I

APPLICANT INFORMATION

I HEREBY APPLY FOR ALL INSURANCE BENEFITS PAYABLE TO ME UNDER THE SOCIAL SECURITY ACT, AS AMENDED.

3. APPLICANT'S SS NUMBER ☐☐-☐☐-☐☐☐☐
☐ **MALE** ☐ **FEMALE**

4. APPLICANT'S FULL NAME
FIRST NAME *MIDDLE NAME* *LAST NAME*

5. NAME USED AT BIRTH

6. OTHER NAMES USED

7. DATE OF BIRTH ☐☐ ☐☐ ☐☐
MONTH DAY YEAR

8. PRESENT AGE

9. ADDRESS (CURRENT LOCATION) P.O. BOX NO. (IF ANY) MUNICIPALITY STATE ZIP CODE

10. TEL. NO.

11. CITIZENSHIP ☐ **FSM** ☐ **PALAU** ☐ **MARSHALLS** ☐ **U.S.** ☐ **OTHER** _____

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
$_____ **PER** _____

14. CURRENT EMPLOYER (IF APPLICABLE)
A. EMPLOYER NAME
B. ADDRESS OR PLACE OF BUSINESS:

15. ARE YOU A SOLE PROPRIETOR OF A BUSINESS?
☐ **YES** ☐ **NO**
A. IF YES, WHAT IS THE BUSINESS NAME?
B. EMPLOYER ID NO:

16. MARITAL STATUS. CHECK ONE AND ENTER THE DATE IF WIDOWED OR DIVORCED.
☐ MARRIED ☐ SINGLE ☐ WIDOWED, Date_____ ☐ Divorced, Date_____

17. SPOUSE'S NAME
FIRST NAME MAIDEN NAME

18. SPOUSE'S SS NUMBER ☐☐-☐☐-☐☐☐☐

19. SPOUSE'S DATE OF BIRTH ☐☐ ☐☐ ☐☐
MONTH DAY YEAR

20. DATE OF MARRIAGE

21. PLACE OF MARRIAGE

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: WHEN:

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?	27. IF NO, ENTER THE DATE YOU WERE ABLE TO RETURN TO WORK.
☐☐ ☐☐ ☐☐ MONTH DAY YEAR	☐ YES ☐ NO	☐☐ ☐☐ ☐☐ MONTH DAY YEAR

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 INFORMATION NEEDED TO PROCESS YOUR APPLICATION FOR BENEFITS? ☐ YES ☐ NO

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

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)	(PRINT NAME AND SIGN)
_____	_____
DATE	DATE
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: _____)

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.

FSM SOCIAL SECURITY OFFICES

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

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

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

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.