FEDERATED STATES OF MICRONESIA
SOCIAL SECURITY ADMINISTRATION
Headquarters: P.O. Box L
Kolonia, Pohnpei State FM 96941

APPLICATION FOR SOCIAL SECURITY INSURANCE BENEFITS

FSMSS-101A
Revised 8/2004

☐ **SURVIVING SPOUSE** ☐ **SURVIVING CHILD/CHILDREN**

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

A. DECEASED WORKER INFORMATION

DECEASED WORKER'S SS NUMBER	DECEASED WORKER'S FULL NAME		
☐☐-☐☐-☐☐☐☐	*FIRST NAME*	*MIDDLE NAME*	*LAST NAME*
DECEASED WORKER'S SEX ☐ MALE ☐ FEMALE	**DECEASED WORKER'S DATE OF BIRTH** ☐☐ ☐☐ ☐☐ MONTH DAY YEAR		**DECEASED WORKER'S DATE OF DEATH** ☐☐ ☐☐ ☐☐ MONTH DAY YEAR

WAS THE DECEASED WORKER EVER ENTITLED TO SOCIAL SECURITY BENEFITS? ☐ YES ☐ NO

IF YES, WHAT KIND OF BENEFITS?

☐ RETIREMENT ☐ DISABILITY ☐ SURVIVOR ☐ LUMP SUM

B. SURVIVING SPOUSE ONLY

NAME:

WERE YOU AND THE DECEASED LIVING TOGETHER AT THE TIME OF DEATH? ☐ YES ☐ NO

IF NO, STATE REASON WHY NOT. _____

ARE YOU RECEIVING A SOCIAL SECURITY BENEFIT CHECK? IF YES, GIVE SOCIAL SECURITY NUMBER UNDER WHICH BENEFITS ARE PAID. ☐ YES SS NUMBER: ☐☐-☐☐-☐☐☐☐ ☐ NO

IF YES, WHAT KIND OF BENEFITS?

☐ RETIREMENT ☐ DISABILITY ☐ SURVIVOR ☐ LUMP SUM

HAVE YOU REMARRIED SINCE THE DEATH OF YOUR SPOUSE? ☐ YES IF YES, WHEN? ☐☐ ☐☐ ☐☐ MONTH DAY YEAR ☐ NO

HAVE YOU REMARRIED SINCE THE DEATH OF YOUR SPOUSE? ☐ YES IF YES, WHEN? ☐☐ ☐☐ ☐☐ MONTH DAY YEAR ☐ NO

C. OTHER SURVIVORS

NAME:	YOUR RELATIONSHIP TO THE DECEASED

IF YOU ARE NOT THE SURVIVING SPOUSE OF THE DECEASED WAGE EARNER, PLEASE EXPLAIN WHY YOU ARE APPLYING FOR BENEFITS _____

IS THERE A SURVIVING PARENT OF DECEASED WAGE EARNER? YES NO

IF YES, ENTER NAME OF MOTHER: _____

ENTER NAME OF FATHER: _____

PART III

D. SURVIVING CHILDREN INFORMATION

DID THE DECEASED WORKER HAVE ANY DEPENDENT CHILDREN WHO WERE:

UNDER AGE 18	**IF YES, INDICATE NUMBER NEXT TO YES**	☐ YES _____	☐ NO
BETWEEN AGE 18 AND 22 PRESENTLY ATTENDING SCHOOL		☐ YES _____	☐ NO
UNDER A DISABILITY THAT BEGAN BEFORE AGE 22		☐ YES _____	☐ NO

Total number of children _____

LIST ALL SUCH CHILDREN IN THE SPACES BELOW BEGINNING WITH THE OLDEST. IF THE CHILD IS CUSTOMARILY ADOPTED CHILD OR STEPCHILD OF THE DECEASED WORKER, USE THE COLUMN LABELED 'OTHER' TO DESCRIBE THE RELATIONSHIP OF THE CHILD TO THE DECEASED WORKER.

TABLE 1

NAME	SS NUMBER	DATE OF BIRTH MONTH DAY YEAR	*NATURAL* ✔	*ADOPTED* ✔	*STEPCHILD* ✔	*OTHER* ✔	*RELATIONSHIP TO DECEASED*
1.	☐☐-☐☐☐☐☐☐	☐☐ ☐☐ ☐☐					
2.	☐☐-☐☐☐☐☐☐	☐☐ ☐☐ ☐☐					
3.	☐☐-☐☐☐☐☐☐	☐☐ ☐☐ ☐☐					
4.	☐☐-☐☐☐☐☐☐	☐☐ ☐☐ ☐☐					
5.	☐☐-☐☐☐☐☐☐	☐☐ ☐☐ ☐☐					
6.	☐☐-☐☐☐☐☐☐	☐☐ ☐☐ ☐☐					
7.	☐☐-☐☐☐☐☐☐	☐☐ ☐☐ ☐☐					
8.	☐☐-☐☐☐☐☐☐	☐☐ ☐☐ ☐☐					
9.	☐☐-☐☐☐☐☐☐	☐☐ ☐☐ ☐☐					
10.	☐☐-☐☐☐☐☐☐	☐☐ ☐☐ ☐☐					

ARE ALL OF THE CHILDREN NAMED ABOVE LIVING IN THE SAME HOUSE AS THE DECEASED? ☐ **YES** ☐ **NO**

HAS ANY OF THE CHILDREN ABOVE BEEN RECEIVING SOCIAL SECURITY BENEFITS? ☐ **YES** ☐ **NO**

NAME OF CHILD	NAME OF WAGE EARNER	WAGE EARNER'S SS NUMBER

IF ANY OF THE CHILDREN NAMED ABOVE HAD BEEN ADOPTED BY SOMEONE OTHER THAN THE DECEASED, GIVE:

NAME OF CHILD	NAME OF CHILD

E. GUARDIAN'S STATEMENT OF RESPONSIBILITY

I UNDERSTAND THAT ALL PAYMENTS MADE TO ME ON BEHALF OF A CHILD MUST BE SPENT FOR THE CHILD'S CARE.

I AGREE TO NOTIFY SOCIAL SECURITY PROMPTLY WHEN MY ADDRESS OR THE ADDRESS OF ANY PERSON FOR WHOM I RECEIVE BENEFIT CHANGES, OR IF I NO LONGER HAVE RESPONSIBILITY FOR THE BENEFITS.

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

1. A CHILD IS ADOPTED OR THERE IS A CHANGE IN CUSTODY.
2. ANY CHILD GOES TO WORK, GETS MARRIED, OR DIES.
3. A STUDENT AGE 18 OR OVER STOPS ATTENDING SCHOOL.
4. A DISABLED CHILD'S CONDITION IMPROVES.

SIGNATURE OF APPLICANT: _____ DATE: _____

PART IV

APPLICANT'S STATEMENT

TO BE SIGNED BY APPLICANT

I HEREBY 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:

☐ **SURVIVING SPOUSE APPLICATION**

1. ***Death Certificate of deceased wage earner***
2. ***Marriage Certificate (Proof of Marriage)***

☐ **SURVIVING CHILDREN APPLICATION**

1. ***Birth Certificates***
2. ***Death Certificate of deceased wage earner***
3. ***Adoption papers***
4. ***Court Appointment of guardianship (if other than spouse of deceased)***
5. ***School Certification (child over 18)***

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.