PRIOR SERVICE TRUST FUND

FSM

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

PSS-010
Revised 4/2006

APPLICATION FOR PRIOR SERVICE BENEFITS

FOR OFFICE USE ONLY	PERSON TO CONTACT ABOUT YOUR CLAIM:
CLAIM NUMBER ☐☐-☐☐-☐☐☐☐	_____
DATE FILED (AT BRANCH)	TELEPHONE NUMBER:
DATE RECEIVED AT HQ	_____

SURVIVING SPOUSE ☐ **SURVIVING CHILDREN** ☐

PART I

SURVIVING SPOUSE

1. ENTER YOUR MAIDEN NAME — FIRST NAME _____ MIDDLE NAME _____ LAST NAME _____

2. ENTER YOUR DATE OF BIRTH ☐☐ ☐☐ ☐☐ (MONTH DAY YEAR)

3. PLACE OF BIRTH _____

4. WERE YOU MARRIED BEFORE YOUR MARRIAGE TO THE DECEASED?

TO WHOM MARRIED	WHEN	WHERE
_____	_____	_____
HOW MARRIAGE ENDED	**WHEN**	**WHERE**
_____	_____	_____

5. YOUR MARRIAGE WAS PERFORMED BY:
   CLERGYMAN OR AUTHORIZED PUBLIC OFFICIAL _____, OTHER _____.
   PLEASE EXPLAIN:
   _____
   _____
   _____

6. DATE OF MARRIAGE ☐☐ ☐☐ ☐☐ (MONTH DAY YEAR)

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

8. HAVE YOU BEEN WORKING SINCE THE DEATH OF YOUR SPOUSE? ☐ YES ☐ NO
   IF YES, SINCE WHEN? ☐☐ ☐☐ ☐☐ (MONTH DAY YEAR)
   NAME OF EMPLOYER _____ LOCATION _____

9. HOW MUCH WERE YOUR TOTAL EARNINGS AT THE END OF THE LAST CALENDAR YEAR (INCLUDING SELF EMPLOYMENT)? _____

10. HOW MUCH HAVE YOU EARNED SO FAR THIS CALENDAR YEAR? _____

11. ARE YOU UNABLE TO WORK BECAUSE OF AN ILLNESS OR DISABLING CONDITION? ☐ YES ☐ NO

12. HAVE YOU EVER BEFORE FILED AN APPLICATION FOR PRIOR SERVICE BENEFITS? ☐ YES ☐ NO

13. IF YES, WHAT KIND OF APPLICATION DID YOU FILE?
☐ RETIREMENT ☐ DISABILITY ☐ SURVIVOR

14. DO YOU AGREE TO NOTIFY THE PSTF-FSM THROUGH THE FSMSSA PROMPTLY IF ANY OF THE FOLLOWING OCCUR AND TO PROMPTLY RETURN ANY BENEFIT CHECK YOU RECEIVE WHICH IS NOT DUE? ☐ YES ☐ NO

A. YOU GO TO WORK
B. YOU REMARRY _____ INITIAL HERE

15. ARE YOU RECEIVING A PRIOR SERVICE BENEFIT? ☐ YES ☐ NO

IF YES, GIVE SOCIAL SECURITY NUMBER UNDER WHICH BENEFITS ARE PAID ☐☐-☐☐-☐☐☐☐

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**

FOR SURVIVING SPOUSE ONLY

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. **SS NUMBER:** ☐☐-☐☐☐☐☐☐☐

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**

IF YOU ARE NOT THE SURVIVING SPOUSE OF THE WAGE EARNER, PLEASE EXPLAIN WHY YOU ARE APPLYING FOR BENEFITS. ARE YOU THE GUARDIAN OF THE CHILDREN?

☐ **YES** ☐ **NO**

PLEASE EXPLAIN YOUR RELATIONSHIP TO THE SURVIVING CHILD/CHILDREN:

PART II

SURVIVING CHILDREN

1. DID THE DECEASED WORKER HAVE ANY CHILDREN DURING THE YEAR BEFORE HIS/HER DEATH WHO WERE:

	IF YES, INDICATE NUMBER NEXT TO YES		
UNDER AGE 18		☐ 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 _____

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

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

3. ARE ALL OF THE CHILDREN NAMED ABOVE LIVING IN THE SAME HOUSE AS YOU? ☐ YES ☐ NO
IF NO, GIVE THE NAME OF THE CHILD NOT LIVING WITH YOU ALONG WITH THE NAME AND ADDRESS OF THE PERSON WITH WHOM THE CHILD IS LIVING.

4. WERE ALL THE CHILDREN IN ITEM #2 LIVING WITH THE DECEASED AT THE TIME OF DEATH? ☐ YES ☐ NO
IF NO, LIST EACH CHILD NOT LIVING WITH THE DECEASED AT THE TIME OF HIS DEATH AND STATE WHETHER OR NOT THE CHILD WAS BEING SUPPORTED BY THE DECEASED.

5. IF ANY OF THE CHILDREN IN ITEM #2 ARE ADOPTED CHILDREN OF THE DECEASED, GIVE THE FOLLOWING:

NAME OF CHILD	ADOPTED IN COURT?	DATE OF ADOPTION
_____	☐ YES ☐ NO	_____
_____	☐ YES ☐ NO	_____

6. IF ANY OF THE CHILDREN IN ITEM #3 HAVE BEEN ADOPTED BY SOMEONE OTHER THAN THE DECEASED, GIVE:

NAME OF CHILD	ADOPTED IN COURT?	DATE OF ADOPTION
_____	☐ **YES** ☐ **NO**	_____
_____	☐ **YES** ☐ **NO**	_____

7. IF ANY OF THE CHILDREN IN ITEM #3 HAS A LEGAL GUARDIAN, GIVE THE NAME OF THE CHILD AND THE NAME AND ADDRESS OF THE GUARDIAN.

8. IF ANY OF THE CHILDREN IN ITEM #3 HAS BEEN MARRIED, GIVE THE NAME OF THE CHILD, THE DATE OF THE MARRIAGE, AND, IF MARRIAGE HAS ENDED, THE DATE THE MARRIAGE ENDED AND HOW IT ENDED.

9. IF AN APPLICATION FOR MONTHLY PRIOR SERVICE BENEFITS HAS EVER BEEN FILED ON BEHALF OF ANY CHILD LISTED IN ITEM #2, GIVE THE NAME OF THE CHILD AND THE NAME AND SOCIAL SECURITY NUMBER OF THE PERSON ON WHOSE EARNINGS RECORD THE CLAIM WAS BASED.

10. DO YOU UNDERSTAND THAT ALL PAYMENTS MADE TO YOU ON BEHALF OF A CHILD MUST BE SPENT FOR THE CHILD'S PRESENT NEEDS, OR, IF NOT PRESENTLY NEEDED, SAVED FOR THE CHILD'S FUTURE NEEDS, AND, DO YOU AGREE TO USE THE BENEFIT THAT WAY?
☐ YES ☐ NO

11. DO YOU AGREE TO FILE THE ANNUAL REPORT OF EARNINGS WHEN ACQUIRED? ☐ YES ☐ NO

12. DO YOU AGREE TO NOTIFY PSTF-FSM THROUGH THE FSMSSA PROMPTLY WHEN YOUR ADDRESS OR THE ADDRESS OF ANY PERSON FOR WHOM YOU RECEIVE BENEFITS CHANGES, OR IF YOU NO LONGER HAVE RESPONSIBILITY FOR THE WELFARE AND CARE OF ANY CHILD FOR WHOM YOU ARE RECEIVING BENEFITS?
☐ YES ☐ NO

13. DO YOU AGREE TO NOTIFY PSTF-FSM THROUGH THE FSMSSA PROMPTLY IF ANY OF THE FOLLOWING OCCUR AND TO PROMPTLY RETURN ANY BENEFIT CHECK YOUR RECEIVED WHICH IS NOT DUE? ☐ YES ☐ NO

A. THE CHILD IS ADOPTED OR THERE IS A CHANGE IN CUSTODY
B. ANY CHILD GOES TO WORK, GETS MARRIED, OR DIES
C. A STUDENT AGE 18 OR OVER STOPS ATTENDING SCHOOL
D. A DISABLED CHILD'S CONDITION IMPROVES

_____
INITIAL HERE

SIGNATURE: I KNOW THAT ANYONE WHO MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION OF MATERIAL FACT IN AN APPLICATION FOR USE IN DETERMINING A RIGHT TO PAYMENT UNDER THE PRIOR SERVICE TRUST FUND SYSTEM COMMITS A CRIME PUNISHABLE BY FINE, IMPRISONMENT OR BOTH. I AFFIRM THAT ALL INFORMATION I HAVE GIVEN IN THIS DOCUMENT IS TRUE.

SIGN HERE _____ DATE: _____

MAILING ADDRESS: PHONE: _____

TOWN/VILLAGE/AND COUNTRY ZIP CODE: _____

RESIDENCE:

DIRECT DEPOSIT:

IF YOU WANT YOUR PAYMENTS SENT DIRECTLY TO THE BANK, CHECK HERE ☐

PLEASE ENTER YOUR BANK'S _____

NAME _____

YOUR ACCOUNT NUMBER _____

BANK ADDRESS _____

ZIP CODE _____

WITNESSES: REQUIRED ONLY IF THIS APPLICATION HAS BEN SIGNED BY (X). IF SIGNED BY MARK (X), TWO WITNESSES TO THE SIGNING WHO KNOW THE APPLICANT MUST SIGN BELOW, GIVING THEIR FULL ADDRESSES.

SIGN HERE _____
(PRINT NAME AND SIGN)

ADDRESS: _____

SIGN HERE _____
(PRINT NAME AND SIGN)

ADDRESS: _____

NOTE: YOU MUST SUBMIT THE FOLLOWING DOCUMENTS TO ACCOMPANY THIS APPLICATION:

A. BIRTH CERTIFICATE

B. STUDENT CERTIFICATION (FOR CHILDREN OVER 17 BUT BELOW 22)

C. ADOPTION QUESTIONNAIRE A & B (IF THERE ARE ADOPTED CHILDREN)

D. DISABILITY DOCUMENT FOR CHILDREN BELOW 22

FSM SOCIAL SECURITY OFFICES AND BRANCHES

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.