



**FSM Social Security Administration**  
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FSMSS-118  
 Sept. 2008

**QUESTIONNAIRE**

<input type="checkbox"/> <b>Retirement</b> 1. Are you working now? <input type="checkbox"/> yes <input type="checkbox"/> no If yes, since when? _____ <p align="center"><b>Date</b></p>	<input type="checkbox"/> <b>Disability</b> 1. Are you working now? <input type="checkbox"/> yes <input type="checkbox"/> no If yes, since when? _____ <p align="center"><b>Date</b></p> 2. Has your condition improved? <input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> <b>Surviving Spouse or</b> <input type="checkbox"/> <b>Guardian (skip to item 4)</b> 1. Are you working ? <input type="checkbox"/> yes <input type="checkbox"/> no If yes, since when? _____ <p align="center"><b>Date</b></p> 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 <b>married?</b> <input type="checkbox"/> yes <input type="checkbox"/> no <b>working?</b> <input type="checkbox"/> yes <input type="checkbox"/> no <b>adopted?</b> <input type="checkbox"/> yes <input type="checkbox"/> no <b>no longer live with you?</b> <input type="checkbox"/> yes <input type="checkbox"/> no  _____ name of child <span style="float:right">ss number</span> <b>died?</b> <input type="checkbox"/> yes <input type="checkbox"/> no  _____ name of child <span style="float:right">ss number</span>  _____ <p align="center">Wage Earner's Name</p>
<p><b>This section for all. Do not leave blank.</b></p> Retiree, disability recipient, or surviving spouse died? <input type="checkbox"/> yes <input type="checkbox"/> no Who died? _____ (print name) _____ (ss #) <span style="float:right">(when?)</span>		

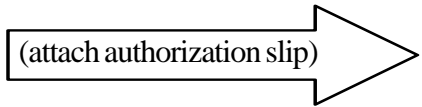
**BENEFICIARY'S DECLARATION**

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: \_\_\_\_\_



Relationship to Beneficiary: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Current Address: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Telephone No.: \_\_\_\_\_

Cell Phone No.: \_\_\_\_\_

Municipality: \_\_\_\_\_