

MODIFIED BENEFIT FORMULA QUESTIONNAIRE--FOREIGN PENSION

NAME OF WAGE EARNER OR SELF-EMPLOYED PERSON	U.S. SOCIAL SECURITY NUMBER
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NAME OF PERSON MAKING STATEMENT (if other than above wage earner or self-employed person)

Privacy Act Statement : Section 215 of the Social Security Act, as amended, authorizes us to collect the information on this form. The information you provide will be used to determine the effect of your pension on your Social Security benefits. Your response is voluntary. However, failure to provide the requested information may prevent an accurate and timely decision on any claim filed, or could result in the loss of benefits.

We rarely use the information provided on this form for any purpose other than for determining the amount of the Social Security benefit you are entitled to receive. However, in accordance with 5 U.S.C. § 552a(b) of the Privacy Act, we may disclose the information provided on this form (1) to enable a third party or an agency to assist Social Security in establishing rights to Social Security benefits and/or coverage; (2) to make determinations for eligibility in similar health and income maintenance programs at the Federal, state and local level; (3) to comply with Federal laws requiring the disclosure of the information from our records; and (4) to facilitate statistical research, audit or investigative activities necessary to assure the integrity of SSA programs.

We may also use the information you provide when we match records by computer. Computer matching programs compare our records with those of other Federal, state or local government agencies. Information from these matching programs can be used to establish or verify a person's eligibility for federally funded or administered benefit programs and for repayment of payments or delinquent debts under these programs. The law allows us to do this even if you do not agree to it. A complete list of routine uses for this information is contained in our System of Records Notice 60-0089 (Claims Folders System). Additional information regarding this form and our other system of records notices and Social Security programs are available from our Internet website at www.socialsecurity.gov or at your local Social Security office.

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 10 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. To find the nearest office call 1-800-772-1213 (TTY 1-800-325-0778) . Send only comments on our time estimate above to: SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.**

U.S Social Security retirement or disability benefits may be determined using a different formula under the Windfall Elimination Provisions (WEP), when you also receive a pension based on employment or self-employment, (employment, meaning work) from a foreign pension not covered by U.S. Social Security. Social Security benefit amounts use only earnings covered under Social Security with a benefit formula that gives proportionately higher amounts to workers with low lifetime earnings. A worker with a substantial period of non-covered work during their lifetime appears to have lower lifetime earnings than they actually had. WEP reduces the primary insurance amount upon which benefits are based and affects all benefits paid on that record except survivors. The difference in U.S. Social Security benefits computed under WEP cannot be greater than one-half the amount of the non-covered pension received in the first month you are entitled to both the non-covered pension and the U.S. Social Security benefit.

1.	Enter the name and address of the agency or organization from which you received or expect to receive the pension. If you receive more than one pension, complete a separate form for each pension.	NAME <hr/> ADDRESS <i>(Include postal code)</i>
2.	Is the pension listed in item 1 a partial benefit paid under a U.S. Social Security (Totalization) agreement?	<input type="checkbox"/> YES If "yes," submit evidence such as an award certificate or letter from the agency paying the pension, ignore the rest of the form, and sign your name on the last page in the appropriate space. <input type="checkbox"/> NO If "no," complete the rest of the form and sign it. <input type="checkbox"/> UNKNOWN If "unknown," contact the agency paying the pension for further information about the pension, complete the form and sign it.
3.	Enter the entire period(s) of employment or self-employment upon which your pension is based. Provide specific dates. Enter a "?" if some information is unknown.	FROM: <i>(month, day, year)</i> <hr/> TO: <i>(month, day, year)</i>
4.	Enter only the period(s) of employment or self-employment from item 3 above used to determine your pension which was after 1956 and which was not covered by U.S. Social Security. Provide specific dates. Enter a "?" if some information is unknown.	FROM: <i>(month, day, year)</i> <hr/> TO: <i>(month, day, year)</i>

5.	Enter specific periods of voluntary contributions or other non-employment based credits included in the computation of your pension. Enter a "?" if some information is unknown.	FROM: (month, day, year)
		TO: (month, day, year)
6.	Enter the date you first became (or expect to become) eligible for the pension.	DATE: (month, day, year)
7.	Enter the amount of your pension before any deductions are made to provide for a survivor annuity, health insurance, etc. (If the pension is not paid in U.S. dollars, show the amount of the pension in the currency in which it is paid.)	
	a) For the month you first receive a U.S. Social Security benefit. _____ OR b) For the month you first receive the pension, if later than the month you first receive a U.S. Social Security benefit. _____ If the pension is paid on other than a monthly basis, indicate how often it is paid.	Amount _____ Amount _____ <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Other _____ If the amount of the pension is unknown, show "unknown."
8.	If you received a lump sum payment instead of a periodic pension, enter the amount of the payment and, if known, the specific period of time for which the payment would be due. If unknown, show "unknown." \$ _____ for the period from _____ through _____ (Amount) (Month, Year) (Month, Year or Lifetime)	

Remarks:

IMPORTANT INFORMATION: PLEASE READ THE FOLLOWING BEFORE SIGNING THE FORM

I agree to report promptly to the U.S. Social Security Administration if my current pension or annuity ceases because this may affect the amount of my U.S. Social Security benefit. I understand that failure to report cessation of my pension or annuity could result in a lower U.S. Social Security benefit than would otherwise be payable. I also agree to report promptly to the U.S. Social Security Administration if I become entitled to another pension or annuity from any country or foreign employer after the cessation of the pension or annuity I currently receive or expect to receive .

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly gives a false or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime and may be sent to prison, or may face other penalties, or both.

SIGNATURE OF PERSON MAKING STATEMENT

SIGNATURE (First Name, Middle Initial, Last Name) (Write in ink)

SIGN
HERE ►

DATE: (month, day, year)

MAILING ADDRESS (Number and Street, Apt. No., P.O. Box, Rural Route)

TELEPHONE NUMBER(S) AT WHICH YOU MAY BE CONTACTED DURING THE DAY

(Area Code)

CITY AND STATE (or Country)

ZIP CODE OR POSTAL CODE

Witnesses are required ONLY if this statement has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the individual must sign below, giving their full address.

SIGNATURE OF WITNESS

SIGNATURE OF WITNESS

ADDRESS (Number and Street, City, State, Country and ZIP Code/Postal Code)

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