SOCIAL SECURITY ADMINISTRATION

Form Approved
OMB No. 0960-0160

GOVERNMENT PENSION QUESTIONNAIRE

NAME OF WAGE EARNER OF SELF-EMPLOYED PERSON	SOCIAL SECURITY NUMBER ___ ___ ___ / ___ ___ / ___ ___ ___ ___
NAME OF PERSON MAKING STATEMENT (If other than wage earner or self-employed person)	RELATIONSHIP TO WAGE EARNER OR SELF-EMPLOYED PERSON

~~**PRIVACY ACT AND PAPERWORK REDUCTION ACT STATEMENTS:** Your response to this request is voluntary; however, failure to provide all or part of the information could prevent an accurate and timely decision on this claim and could affect your Social Security benefit. The Social Security Administration uses the information you furnish to determine the effect of your worker's compensation or other public disability benefit on your Social Security disability insurance benefit, as provided in section 224 of the Social Security Act (42 U.S.C.424). The information on this form may be disclosed by the Social Security Administration to another person or agency for the following purposes: (1) to assist the Social Security Administration in establishing the right of a beneficiary to Social Security Benefits, (2) to facilitate statistical research and audit activities necessary to assure the integrity and improvement of the Social Security programs, and (3) to comply with laws requiring the exchange of information between the [...] and another agency. We may also use the information you give us when we match records by computer. Matching programs compa[...] Federal, State or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies [...] government. The law allows us to do this even if you do not agree to it.~~

See revised PRA and PA statements below.

~~These and other reasons why information about you may be used or given out are explained in the Federal Register. If you want to learn more about this, contact any Social Security office.~~

~~The **Paperwork Reduction Act of 1995** requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB control number. We estimate that it will take you about 12.5 minutes to complete this form. This includes the time it will take to read the instructions, gather the necessary facts and fill out the form.~~

1. Enter the name and address of the agency or organization below from which your government pension or annuity is received:

NAME OF AGENCY OR ORGANIZATION	ADDRESS OF AGENCY OR ORGANIZATION	PHONE NUMBER OF AGENCY OR ORGANIZATION *(Include area code)*

2. (a) Enter the last day of employment upon which your pension or annuity is based. → MONTH ___ DAY ___ YEAR ___

☐ State ☐ Federal ☐ Local

(b) On the date shown in (a) above, was this employment covered under Social Security for benefit purposes? → ☐ Yes ☐ No

3. (a) What was the first month for which you began <u>receiving</u> your pension or annuity? → MONTH ___ YEAR ___

(b) Could you have been eligible for and received this pension or annuity <u>earlier</u> had you stopped working and made application? (If yes, answer (c).) → ☐ Yes ☐ No

(c) When could you have first received this pension/annuity? → MONTH ___ YEAR ___

4. (a) Did you elect FERS or another covered plan? → ☐ Yes ☐ No

If yes, when? → MONTH ___ YEAR ___

5. (a) Do you receive your pension/annuity weekly, biweekly, or monthly? ______________

What is the current pension amount after any deductions made to provide for a survivor annuity, but before any deductions for health insurance, allotments, bonds, etc.? $ ______________

(b) Did you elect a lump sum payment with a reduced annuity? → ☐ Yes ☐ No

If yes, what is the amount of the annuity before reduction for the lump sum? $ ______________

(c) Did you elect an annuity in one lump sum payment? → ☐ Yes ☐ No

If yes, what is the amount? $ ______________

What was the specific period of time for which the lump sum payment was made?

5.	(d) Has your pension amount changed for any months for which you are applying or have been receiving spouse's or surviving spouse's Social Security benefits? →	☐ Yes ☐ No
	If yes, give the former amount(s) and dates(s) of change below:	

FORMER AMOUNT(S)	DATE(S) OF CHANGE	
	MONTH	YEAR
$		
$		
$		

If the date in either 3(a) or 3(c) is before 7/1/83, answer item 6.

6.	(a) Were you receiving at least one half support from your spouse at the time your spouse became entitled to retirement or disability insurance benefits (or stopped work prior to disability), or if you are a widow or widower at the time your spouse died? →	☐ Yes ☐ No *(If yes, answer (b).)*
	(b) Have you filed proof of such support with the Social Security Administration? →	☐ Yes ☐ No

REMARKS

IMPORTANT INFORMATION—PLEASE READ THE FOLLOWING CAREFULLY AND THEN SIGN BELOW

I agree to promptly report to the Social Security Administration if the amount of my present pension or annuity changes. I understand that my pension or annuity may affect my Social Security benefits and that failure to report such pension or annuity may result in an overpayment which I may have to pay back.

I know that anyone who makes or causes to be made a false statement or representation of material fact in an application or for use in determining a right to payment under the Social Security Act commits a crime punishable under Federal law by fine, imprisonment or both. I affirm that all information I have given in this document is true.

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	ZIP 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 and ZIP Code)*	ADDRESS *(Number and Street, City, State and ZIP Code)*

SSA will insert the following revised PRA Statement into the form at its next scheduled reprinting:

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 12.5 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. You can find your local Social Security office through SSA's website at www.socialsecurity.gov. Offices are also listed under U. S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213 (TTY 1-800-325-0778).** *You may send comments on our time estimate above to: SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.* ***Send only comments relating to our time estimate to this address, not the completed form.***

Privacy Act Statement

Government Pension Questionnaire

Section 224 of the Social Security Act (42 U.S.C. 424), as amended, authorizes us to collect this information. The information you provide will be used to determine the effect of your worker's compensation or other public disability benefit on your Social Security disability insurance benefit.

The information you furnish on this form is voluntary. However, failure to provide the requested information could prevent an accurate and timely decision on your claim and could affect your Social Security benefit.

We rarely use the information you supply for any purpose other than for making a determination relating to the effect of your worker's compensation or other public disability benefit on your Social Security disability insurance benefit. However, we may use it for the administration and integrity of Social Security programs. We may also disclose information to another person or to another agency in accordance with approved routine uses, which include but are not limited to the following:

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 comply with Federal laws requiring the release of information from Social Security records (e.g., to the Government Accountability Office and Department of Veterans' Affairs);

3. To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level; and,

4. To facilitate statistical research, audit, or investigative activities necessary to assure the integrity and improvement of Social Security programs (e.g., to the Bureau of the Census and private concerns under contract to Social Security).

We may also use the information you provide in computer matching programs. Matching programs compare our records with records kept by 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.

A complete list of routine uses for this information is available in our Systems of Records Notices entitled, Claims Folders Systems, 60-0089 and Master Beneficiary Record, 60-0090. These notices, additional information regarding this form, and information regarding our programs and systems, are available on-line at www.socialsecurity.gov or at your local Social Security office.