Form Approved OMB No. 0960-0561

MODIFIED BENEFIT FORMULA QUESTIONNAIRE--FOREIGN PENSION

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

PRIVACY ACT: Your response to this request is voluntary; however, failure to provide all or part of the requested information could prevent an accurate and timely decision on your claim and could affect your Social Security benefits. The Social Security Administration uses the information you furnish to determine the effect of your pension on your Social Security benefit, as provided in section 215 of the Social Security Act (42 U.S.C. 415). 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 Social Security and another agency.

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it.

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. Send only comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 21235-6401.

A modified benefit formula is used to compute U.S. Social Security benefits for persons entitled to both a pension or annuity based on employment after 1956 not covered by U.S. Social Security (including a government or private pension or annuity based on employment or self-employment, (employment meaning work) in another country) and a U.S. Social Security retirement or disability insurance benefit. The difference in your U.S. Social Security benefit computed under the modified formula, rather than the regular benefit formula, cannot be greater than one-half the amount of the pension or annuity you received in the first month you are entitled to both the pension or annuity and the U.S. Social Security benefit.

1.	Enter the name and address of the agency or organization from	NAME
		ADDRESS (Include postal code)
2.	Is the pension listed in item 1 based on a totalization agreement (combined credits) with the United States?	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. NO If "no", complete the rest of the form and sign it. 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	FROM: (month, day, year) TO: (month, day, year)
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: (month, day, year)
_	Enter specific periods of voluntary contributions	
5.	non-employment based credits included in the compu- your pension. Enter a "?" if some information is unkno	
	your pension. Enter a ! It some information is drikno	WII.
	Enter the date you first became (or expect to become	e) eligible DATE: (month, day, year)
6.	for the pension.	, 3.19.2.10
	Enter the amount of your pension before any deduct	tions are made to provide for a survivor annuity, health
		ars, 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	Amount
_	b) for the month you first receive the pension, if is	ater than
7.	the month you first receive a U.S. Social	
	benefit.	Amount
	If the pension is paid on other than a month	ly basis, Weekly Bi-Weekly Other
	indicate how often it is paid.	Weekly Bi-Weekly Other
		If the amount of the pension is unknown, show
		"unknown."
	If you received a lump sum payment instead of a perio	dic pension, enter the amount of the payment and, if
	known, the specific period of time for which the paym	ent would be due. If unknown, show "unknown."
8.		
	for the period from (Month, Ye	through ear) (Month, Year or Lifetime)
		(MOHIII, Year of Lifetime)
Remari	KS:	
	IMPORTANT INFORMATION: PLEASE READ THE	FOLLOWING BEFORE SIGNING THE FORM
•	o report promptly to the U.S. Social Security Administration if my cur Social Security benefit. I understand that failure to report cessation of	rent pension or annuity ceases because this may affect the amount of
-	han would otherwise be payable. I also agree to report promptly to the	
pension	or annuity from any country or foreign employer after the cessation o	f 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
	ect to the best of my knowledge. I understand that anyone who knowledge.	
this info	rmation, or causes someone else to do so, commits a crime and may	
SIGNAT	SIGNATURE OF PERSON N URE (First Name, Middle Initial, Last Name) (Write in ink)	DATE: (month, day, year)
SIGNAT	ONE (First Ivalie, Wildle Hittal, Last Ivalie) (Wilte III IIIK)	DATE. (month, day, year,
HERE •		
MAILING ADDRESS (Number and Street, Apt. No., P.O. Box, Rural Route)		TELEPHONE NUMBER(S) AT WHICH YOU MAY BE CONTACTED DURING THE DAY
CITY AND STATE (or Country)		(Area Code) ZIP CODE OR POSTAL CODE
CITTAN	D STATE (or Country)	ZIF CODE ON FOSTAL CODE
\A/C+	ONLY if this statement has been simple to make (V)	
	es are required ONLY if this statement has been signed by mark (X) a al must sign below, giving their full address.	pove. If signed by mark (X), two witnesses to the signing who know the
SIGNATURE OF WITNESS SIGNATURE OF WITNESS		GNATURE OF WITNESS
ADDRES	S (Number and Street, City, State, Country and ZIP Code/Postal Code) AL	DDRESS (Number and Street, City, State, Country and ZIP Code/Postal Code)