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)

See Revised Privacy Act Statement

PRIVACY ACT: Your response to this request is voluntary; however, failure to provide the requested information could prevent an accurate and timely decision on your claim and could delay payment. 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.

See Revised PRA Statement

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 which you received or expect to receive the pension. If you receive more than one pension, complete a separate form for each pension.	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 some information is unknown.	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)* TO: *(month, day, year)*

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 _____ ☐ Weekly ☐ Bi-Weekly ☐ 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." $ _____ (Amount) for the period from _____ (Month, Year) through _____ (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)	ADDRESS (Number and Street, City, State, Country and ZIP Code/Postal Code)

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

Privacy Act Notice
Modified Benefit Questionnaire – Foreign Pension

Section 215 of the Social Security Act, as amended, authorizes us to collect this information. We will use the information you provide to determine the effect of your pension on your Social Security benefit.

The information you furnish on this form is voluntary. However, failure to provide all or part of the 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 pension on your Social Security 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 are available in Systems of Records Notices entitled, Claims Folder 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.

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 (OMB) control number. The OMB control number for this collection is 0960-0561. We estimate that it will take between 10 minutes to read the instructions, gather the facts, and answer the questions. ***Send only comments relating to our time estimate above to***: *SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.*