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 Statement Collection and Use of Personal Information~~

~~Section 202 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. Furnishing us this information is voluntary. However, failing to provide us with all or part of the information may 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 making a determination relating to the effect of your pension on your Social Security benefit. However, we may use the information for the administration of our programs including sharing information: 1. To comply with Federal laws requiring the release of information from our records (e.g., to the Government Accountability Office and Department of Veterans Affairs); and, 2. To facilitate statistical research, audit, or investigative activities necessary to assure the integrity and improvement of our programs (e.g., to the Bureau of the Census and to private entities under contract with us). A complete list of when we may share your information with others, called routine uses, is available in our Privacy Act System of Records Notices entitled Claims Folders Systems, 60-0089, and Master Beneficiary Record, 60-0090. Additional information about these and other system of records notices and our programs is available from our Internet website at www.socialsecurity.gov or at your local Social Security office. We may share the information you provide to other health agencies through computer matching programs. Matching programs compare our records with records kept by other Federal, State, or local government agencies. We use the information from these programs to establish or verify a person's eligibility for federally funded or administered benefit programs and for repayment of incorrect payments or delinquent debts under these programs.~~ See Revised Privacy Act Statement Attached

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, 6401Security Blvd, Baltimore, MD 21235-6401.* ***Send only comments relating to our time estimate to this address, not the completed 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. → ☐ State ☐ Federal ☐ Local		MONTH / DAY / YEAR
	(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 receiving your pension or annuity? →		MONTH / YEAR
	(b) Could you have been eligible for and received this pension or annuity earlier 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?		$

5.	(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?		
	(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:	DATE(S) OF CHANGE	
	FORMER AMOUNT(S)	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)*	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 (Include 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)*