

## 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)

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.

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| 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<br><hr/> ADDRESS (include postal code)   |
| 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.<br><br><input type="checkbox"/> No If "no," complete the rest of the form and sign it.<br><br><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 period(s) of employment or self-employment upon which your pension is based. Provide specific dates. Enter a "?" if some information is unknown.   | FROM: (MM/DD/YYYY)<br><hr/> TO: (MM/DD/YYYY)  |
| 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: (MM/DD/YYYY)<br><hr/> TO: (MM/DD/YYYY)  |
| 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: (MM/DD/YYYY)<br><hr/> TO: (MM/DD/YYYY)  |
| 6. | Enter the date you first became (or expect to become) eligible for the pension.  | DATE: (MM/DD/YYYY)  |

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.)

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| 7. a) For the month you first receive a U.S. Social Security benefit.  | AMOUNT  |
| OR   |   |
| b) For the month you first receive the pension, if later than the month you first receive a U.S. Social Security benefit | AMOUNT  |
| If the pension is paid on other than a monthly basis, indicate how often it is paid                                      | <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Other _____<br>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.

**SIGNATURE OF PERSON MAKING STATEMENT**

|  |  |
|--|--|
| SIGNATURE ( <i>First name, Middle Initial, Last Name</i> ) ( <i>Write in ink</i> ) | DATE: ( <i>MM/DD/YYYY</i> )                                      |
| MAILING ADDRESS ( <i>Number and Street, Apt. No., P.O. Box, Rural Route</i> )      | TELEPHONE NUMBER(S) AT WHICH YOU MAY BE CONTACTED DURING THE DAY |
| CITY AND STATE ( <i>or Country</i> )   | 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.

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| SIGNATURE OF WITNESS   | SIGNATURE OF WITNESS   |
| ADDRESS ( <i>Number and Street, City, State, Country, and ZIP Code/Postal Code</i> ) | ADDRESS ( <i>Number and Street, City, State, Country, and ZIP Code/Postal Code</i> ) |

## Privacy Act Statement Collection and Use of Personal Information

Sections 205(a) and (c), and 215(a)(7) and (d)(3) of the Social Security Act, as amended, allow us to collect this information. Furnishing us this information is voluntary. However, failing to provide all or part of the information may prevent an accurate and timely decision on any claim filed or could result in the loss of benefits.

We will use the information to determine the effect of your foreign pension on your Social Security benefits. We may also share your information for the following purposes, called routine uses:

1. To third party contacts in situations where the party to be contacted has, or is expected to have, information relating to the individual's capability to manage his or her affairs or his or her eligibility for or entitlement to benefits under the Social Security program when the data are needed to establish the validity of evidence or to verify the accuracy of information presented by the individual, and it concerns the amount of his or her benefit payment; and,
2. To applicants, claimants, prospective applicants or claimants, other than the data subject, their authorized representatives or representative payees to the extent necessary to pursue Social Security claims and to representative payees when the information pertains to individuals for whom they serve as representative payees, for the purpose of assisting SSA in administering its representative payment responsibilities under the Act and assisting the representative payees in performing their duties as payees, including receiving and accounting for benefits for individuals for whom they serve as payees.

In addition, we may share this information in accordance with the Privacy Act and other Federal laws. For example, where authorized, we may use and disclose this information in computer matching programs, in which our records are compared with other records to establish or verify a person's eligibility for Federal benefit programs and for repayment of incorrect or delinquent debts under these programs.

A list of additional routine uses is available in our Privacy Act System of Records Notices (SORN) 60-0089, entitled Claims Folders Systems, and 60+0090, entitled Master Beneficiary Record. Additional information and a full listing of all our SORNs are available on our website at [www.ssa.gov/privacy/sorn.html](http://www.ssa.gov/privacy/sorn.html).

## 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.