AUTHORIZATION TO CEASE ALLOTMENT

FSM SOCIAL SECURITY ADMINISTRATION

FSMSS-113b Rev. 10/2020

Beneficiary Name:______________________________________ Date: ______________________

Wage Earner: ____

Address: ____
____ Zip Code: ___________________________

I WOULD LIKE TO REQUEST THAT ANY AMOUNT OF MY SS MONTHLY BENEFIT CHECK MADE PAYABLE TO

Allottee/Org.:____
Address:____ Zip Code: __________________
Name of Acct. /Number:____

BE CEASED IMMEDIATELY UPON RECEIPT OF THIS FORM.

Reason for request:____
____

Beneficiary’s Signature:___________________________________ ID. # (if any):_______________

Witnessed by (FSMSSA Staff):_____________________________________ Date:_______________

DO NOT WRITE BELOW – FOR FSMSS USE ONLY

TYPE OF BENEFIT: ☐ RE ☐ SS ☐ DI BE SS NO.____________________ WE SS NO.____________________	CLAIM DIVISION ALLOTTEE CODE ________________ VERIFIED BY: ____________________ ________________ EFFECTIVE DATE
APPROVED BY: ______________________________ Alexander R. Narruhn, Administrator	____________________________ Date

FSMSS is not liable for any delayed and/or late payments, charged interest, etc. that may have incurred due to computer technicalities if any.