



**FSM Social Security Administration**  
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FSMSS-118  
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**QUESTIONNAIRE**

Dear Beneficiary:

Please complete this survey and submit it to our office as soon as possible. Failure to do so will result in benefit withholding. Thank you.

<input type="checkbox"/> Retirement	<input type="checkbox"/> Disability	<input type="checkbox"/> Surviving Spouse or <input type="checkbox"/> Guardian (skip to item 4)
1. Are you working now? <input type="checkbox"/> yes <input type="checkbox"/> no If yes, since when? Date: _____	1. Are you working now? <input type="checkbox"/> yes <input type="checkbox"/> no If yes, since when? Date: _____  2. Has your condition improved? <input type="checkbox"/> yes <input type="checkbox"/> no	1. Are you working? <input type="checkbox"/> yes <input type="checkbox"/> no If yes, since when? Date: _____ 2. Have you remarried? <input type="checkbox"/> yes <input type="checkbox"/> no 3. Do you have children receiving social security benefits? yes no 4. Are any of the children receiving social security benefits <b>married?</b> <input type="checkbox"/> yes <input type="checkbox"/> no <b>working?</b> <input type="checkbox"/> yes <input type="checkbox"/> no <b>adopted?</b> <input type="checkbox"/> yes <input type="checkbox"/> no <b>no longer live with you?</b> <input type="checkbox"/> yes <input type="checkbox"/> no  _____ name of child ss number <b>died?</b> <input type="checkbox"/> yes <input type="checkbox"/> no  _____ name of child ss number  Wage Earner's Name: _____
<b>This section is for all. Do not leave blank.</b> Retiree, disability recipient, or surviving spouse died? <input type="checkbox"/> yes <input type="checkbox"/> no Who died? _____ (print name)  (ss #) (when?)		

**IMPORTANT:**

- This survey form must be notarized if not signed in the presence of a representative of the FSMSSA.

**BENEFICIARY'S DECLARATION**

I understand that any false statement or misrepresentation of any fact in maintaining a right for benefits is a crime punishable under Title 53 of the FSM Code.

Beneficiary's Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Beneficiary's Current Address: \_\_\_\_\_ How long have you been  
\_\_\_\_\_ at this address? \_\_\_\_\_

Telephone No.: \_\_\_\_\_

Cell phone No.: \_\_\_\_\_

Email Address: \_\_\_\_\_

Municipality: \_\_\_\_\_ Interviewer: \_\_\_\_\_