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:

_____ _____
Leon Panuelo, Jr. 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.