MARSHALL ISLANDS SOCIAL SECURITY ADMINISTRATION

Post Office Box 175 • Majuro, Republic of the Marshall Islands MH 96960

Tel.: (692) 625-3101 • Fax: (692) 625-3819

MISSA–200
08/93

Claim Number : _____ Branch Office : _____

Date Filed : _____ Person to contact about your claim : _____

Date Logged : _____ Telephone Number : _____

APPLICATION FOR DISABILITY INSURANCE BENEFITS

PART I

I hereby apply for all insurance benefits payable to me under the Social Security Act, as amended.

1. Enter your social security number: ☐☐–☐☐☐☐☐☐☐

First Middle Last

2. Print your full name:

3. Name used at birth:

4. Other names used:

5. Male: ___ Female: ___

6. Enter your place of birth

7. Enter your date of birth: (Month/Day/Year)

8. Enter your present age:

9. MARITAL STATUS. (✓) Check one. Enter the date if widowed or divorced.

Married: ____ Widowed: ____ Date: _____

Single : ____ Divorced: ____ Date: _____

10. Spouse's name or maiden name:

11. Spouse's date of birth (or age if date of birth unknown):

12. Spouse's Social Security Number: ☐☐–☐☐☐☐☐☐☐

13. Your marriage was performed by: Clergyman or authorized public official: ____

Other: ____ Explain: _____

14. Date of marriage: Place of marriage:

15. Were you married before? Yes: ___ No: ___ If yes, provide details.

16. Do you have any dependent children who are,

Under age 18 ..... Yes: _____ No: ____

Between age 18 and 22 presently attending school ..... Yes: _____ No: ____

Under a disability that began before age 22 ..... Yes: _____ No: ____

If yes, indicate number next to yes.

17. If yes, include the following information:

NAME	AGE	DATE OF BIRTH	RELATIONSHIP TO YOU

18. List all employers for whom you worked during the last five (5) years.

NAME AND ADDRESS OF EMPLOYER	WORK BEGAN (month/year)	WORD ENDED (month/year)

19. How much were your total earnings at the end of last calendar year (including self employment)? $

20. How much have you earned so far this calendar year? $

21. Did you work more than 5 years for the Trust Territory Government (including Navy time) before July 1, 1968?

Yes: ____ No: ____

22. Indicate number of years, months, and days you worked for the Trust Territory Government prior to July 1, 1968 and monthly pay rate on July 1, 1968; or monthly pay rate effective on the date of termination prior to July 1, 1968:

Years: _____ Months: _____ Days: _____ Monthly Pay Rate: $ _____

23. Have you ever engaged in work which was covered under any other social security system? Yes: ____ No: ____

If Yes, _____ _____ _____ _____

Country When SS Number Dates

24. Have you ever filed an application for Social Security Benefits? Yes: ____ No: ____

25. If yes, What kind of application did you file? Retirement: ____ Disability : ____

Survivor : ____ Lump Sum: ____

PART II

26. **Describe (in detail) the nature of your disability.**

27. **What month, day and year did you become unable to work because of yor disability?**

    Month _____ Day _____ Year _____

28. **Are you still disabled?** Yes: ____ No: ____

29. **If no, enter the date you were able to return to work.** Month _____ Day _____ Year _____

30. **Have you received or do you expect to receive any kind of worker's compensation benefit?** Yes: ____ No: ____

    If yes, give details.

31. Did you receive any money from your employer(s) on or after the date you said you became unable to work because of disability? Yes: ____ No: ____

32. If yes, please give amounts and explain. $

33. May Social Security ask your employers for information needed to process your application for benefits?

    Yes: ____ No: ____

34. Do you authorize any physician or hospital to disclose to Social Security any medical records or other information about your disability? Yes: ____ No: ____

35. Do you agree to notify Social Security if any of the following events occur? Yes: ____ No: ____

    Your medical condition improves.

    You go back to work or a self employed person.

    You apply for or currently receive any kind of worker's compensation payment.

    _____
    Please initial here

Signature: ***I know that anyone who make or causes to be made a false statement or representation of material fact in an application for use in determining a right to payment under the Social Security Act commits a crime punishable by fine, imprisonment or both. I affirm that all information I have given in this document is true.***

SIGN
HERE: _____ Date: _____

Address: _____ Phone: _____

City and State: _____ ZIP: _____

Residence: _____

Direct Deposit: If yo want your payments sent directly to the bank, check here [ ].

Please enter your bank's name: _____ Bank Account No.: _____

Bank mailing address: _____

_____

_____

Witness: ***Required ONLY if this application has been signed by (X). If signed by mark (X), two witnesses to the signing who know the applicant must sign below, giving their full addresses.***

Sign
Here: _____

Address: _____

_____

Sign
Here: _____

Address: _____

_____