MODIFIED BENEFIT FORMULA QUESTIONNAIRE

NAME OF WAGE EARNER OR SELF-EMPLOYED PERSON	SOCIAL SECURITY NUMBER

NAME OF PERSON MAKING STATEMENT *(if other than above wage earner or self-employed person)*

Privacy Act Statement
Collection and Use of Personal Information

Section 215 of the Social Security Act, as amended, allows us to collect this information. We will use the information you provide to make a determination on the effect of your pension on your Social Security benefit. Furnishing us this information is voluntary. However, failing to provide us with all or part of the information may not allow us to make a correct determination regarding your claim and could affect your Social Security benefit. We rarely use the information you supply for any purpose other than for of your pension on your Social Security benefit. However, we may use the information for the administration of our programs including sharing information: 1. To comply with Federal laws requiring the release of information from our records (e.g., to the Government Accountability Office and Department of Veterans Affairs); and, 2. To facilitate statistical research, audit, or investigative activities necessary to assure the integrity and improvement of our programs (e.g., to the Bureau of the Census and to private entities under contract with us). A complete list of when we may share your information with others, called routine uses, is available in our Privacy Act System of Records Notice 60-0090, entitled, Master Beneficiary Record. Additional information about this and other system of records notices and our programs are available from our Internet website at www.socialsecurity.gov or at your local Social Security office. We may share the information you provide to other health agencies through computer matching programs. Matching programs compare our records with records kept by other Federal, State, or local government agencies. We use the information from these programs to establish or verify a person's eligibility for federally funded or administered benefit programs and for repayment of incorrect payments or delinquent debts under these programs.

A modified benefit formula is used to compute Social Security benefits for persons entitled to both a pension or annuity based on employment after 1956 not covered by Social Security and a Social Security retirement or disability insurance benefit. The difference in your Social Security benefit computed under the modified formula, rather than the regular benefit formula, cannot be greater than one-half the amount of the pension or annuity you received in the first month you are entitled to both the pension or annuity and the Social Security benefit.

1. Enter the name and address of the agency or organization from which the pension or annuity is received or is expected to be received.

NAME	ADDRESS *(include ZIP Code)*	
2. Enter the period(s) of employment upon which your pension or annuity is based (include both employment covered and not covered by Social Security, if applicable). If unknown, show "unknown".	FROM:(month,year)	TO:(month,year)
3. Enter the period(s) of employment after 1956 not covered by Social Security that is used to determine your pension or annuity. If unknown, show "unknown".	FROM:(month,year)	TO:(month,year)

4. Enter the monthly amount of the pension or annuity you are entitled to before any deductions are made to provide for a survivor annuity, health insurance, etc.

a) For the month you first receive a Social Security retirement or disability benefit.	MONTHLY AMOUNT (if amount is unknown, show "unknown".)
OR	
b) For the month you first receive the pension or annuity, if later than the month you first receive a Social Security retirement or disability benefit.	MONTHLY AMOUNT (if amount is unknown, show "unknown".)

5. If you received a lump sum payment in lieu of a monthly pension or annuity, enter the amount of the payment and, if known, the specific period of time for which the payment was made. If unknown, show "unknown".

_____ for the period from _____ through _____

(Amount) (Month, Year) (Month, Year)

REMARKS: (Use this section for any additional information)

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 8 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. You can find your local Social Security office through SSA's website at www.socialsecurity.gov. Offices are also listed under U. S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213 (TTY 1-800-325-0778).** *You may send comments on our time estimate above to: SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.* ***Send only comments relating to our time estimate to this address, not the completed form.***

IMPORTANT INFORMATION: PLEASE READ THE FOLLOWING BEFORE SIGNING THE FORM

I agree to report promptly to the Social Security Administration if my current pension or annuity ceases because this may affect the amount of my Social Security benefit. I understand that failure to report cessation of my pension or annuity could result in a lower Social Security benefit than would otherwise be payable.

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, or both.

SIGNATURE OF PERSON MAKING STATEMENT

SIGNATURE *(First Name, Middle Initial, Last Name) (Write in ink)*	DATE *(Month, Day, Year)*
MAILING ADDRESS *(Number and Street, Apt. No., P.O. Box, Rural Route)*	TELEPHONE NUMBER(S) AT WHICH YOU MAY BE CONTACTED DURING THE DAY ( ) AREA CODE
CITY AND STATE	ZIP 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 addresses.

SIGNATURE OF WITNESS	SIGNATURE OF WITNESS
ADDRESS *(Number and Street, City, State and ZIP Code)*	ADDRESS *(Number and Street, City, State and ZIP Code)*