Republic of Palau

SOCIAL SECURITY ADMINISTRATION

Date Received/Logged: ______________________________

Date Filed/Complete: ______________________________ **Telephone Number**: ___________________________

PART I

APPLICATION FOR DISABILITY INSURANCE BENEFITS

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

1. Your Social Security Number: ☐☐☐–☐☐–☐☐☐☐

First Middle Last

2. Your Full Name:
3. Name Used At Birth/Other Name Used:
4. Address: Phone:

   Current Residence:

   City and State: Zip:

5. Parent's Name: Father _________________________________ Mother _________________________________
6. Male: ___ Female: ___ 7. Birth Place: 8. Citizenship:

Month Day Year

9. Your Date of Birth: ________/_______/_______ 10. Your Present Age: _____________
11. Marital Status: ☐Single ☐ Divorced: Date:________________ ☐ Widowed: Date:_________________

    If Married answer question 12 to 17.

First Middle Last

12. Spouse's Name:

Month Day Year

13. Spouse's Date of Birth (or age if date of birth unknown): ________/_______/________ Age:______________
14. Spouse's Social Security Number: ☐☐☐–☐☐–☐☐☐☐
15. Your marriage was performed by: Clergyman or authorized public official ___________________________

    Other _______________________, Explain:

16. Date of Marriage: 17. Place of Marriage:
18. Do you have any dependent children who are,

	If yes indicate Number next to yes		
Under age 18		Yes ________	No _______
Between the age 18 and 22 presently attending school		Yes ________	No _______
Under a disability that began before age of 22		Yes ________	No _______

19. If yes to item 18 include the following information:

Name	Age	Date of Birth	Relationship to You

PART II

DISABILITY APPLICANT INFOMRATION

20. Are you working or self-employed/own business? No ☐ Date stopped working:_________________________

☐ If Yes, From _________________________ To ______________________________

21. How your earnings affect your benefits: You may earn up to $3,000.00 per quarter and still receive all your disability benefits. If you earn over that amount, $1.00 in benefits will be reduced for each $3.00 of earnings over $3,000.00 per quarter.

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

23. Describe (in detail) the nature of your disability:

24. What month, day and year did you become unable to work because of your disability?

Month ________________________ Day ___________ Year _______________

25. Are you still disabled? ☐ Yes ☐ No

If no, enter the date you were able to return to work. Month _________________ Year ______________

26. I authorize any physician or hospital to disclose to Social Security any medical records or other information about my disability.

27. Have you ever filed an application for Social Security Benefits? ☐ Yes ☐ No

28. If yes, what kind of application did you file? ☐ Survivor ☐ Lump Sum

Give Wage Earner's Name and Social Security Number on which benefits are paid:

Name ____ SSN: _______________________________

29. I agree to notify Social Security if any of the following event(s) occur:
    a. My medical condition improves.
    b. I go back to work or become a self-employed person.
    c. I apply for or currently receive any kind of worker's compensation payment.
    d. Any changes to my marital status (i.e. remarry, divorce or become widow/widower).
    e. If or when I change my address.
    f. Change my Citizenship.

Signature*: I know that anyone who makes 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 acknowledge my agreement to the statements in No. 26 & No.29 and affirm that all information I have given in this document and any attachments are true and correct.*

SIGN HERE: ____ DATE: ___________________________

(Note: This application must be notarized if not signed in the presence of a Social Security Administration Representative).

Remarks:

Direct Deposit: IF you want your payments sent to the bank, check here ☐ ***If checked, please provide a copy of your bank account or a bank statement.***

Your Bank's Name & Address: ________________________________

Your Bank's ABA Number: __________________________________

Your Bank's Account Number: ________________________________ Account Type: ________________

Witness: Required ONLY if this application has been signed by (X), two witnesses to the signing below, giving their full addresses.

Sign Here: ________________________________
(Print Name and Sign)

Address: __________________________________
____

Sign Here: ________________________________
(Print Name and Sign)

Address: __________________________________
____

NOTE: This application will not be processed without the following documents:

1. **Certified Copy** of your **Birth Certificate**
2. At least two (2) of the following original documents that are at least 5 years old prior to the date of this application (**i.e. passport, driver's license, picture identification card, etc**.)
3. Termination Action or Resignation letter
4. If residing overseas, submit **Certified Statement of Earnings**.
5. Copy of Saving or Checking Account: i.e. Bank of Hawaii, Bank of Guam, Bank Pacific