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

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: 

17. If yes, include the following information:

<table>
<thead>
<tr>
<th>NAME</th>
<th>AGE</th>
<th>DATE OF BIRTH</th>
<th>RELATIONSHIP TO YOU</th>
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18. List all employers for whom you worked during the last five (5) years.

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<tr>
<th>NAME AND ADDRESS OF EMPLOYER</th>
<th>WORK BEGAN (month/year)</th>
<th>WORK ENDED (month/year)</th>
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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 your 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 you 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: Sign Here:
Address: Address: