



# SOCIAL SECURITY FUND

P.O.BOX 170, SWEENEYS, MONTSERRAT. Tel.: (664)-491-2567/3667 \* Fax:(664) 491-6145

## AGE BENEFIT CLAIM FORM

To: The Director

Social Security No.

1. (a) SURNAME ..... Christian Name .....

(b) Alias or Other Names .....

2. Date of Birth ..... Sex: Male  Female

3. Current Address .....

Telephone Number .....

Address in Montserrat before 1995 .....

4. Marital Status: Single  Married  Common-Law  Widowed  Divorced  Separated

5. (a) Name of Spouse .....

(b) Address .....

Name of Employer (s)	Period Worked

6. **WARNING** : Any person who knowingly makes any false statement or false representation for the purpose of obtaining benefit will be liable to prosecution.

7. I, the undersigned hereby declare that to the best of my knowledge and belief, the information above is true and accurate.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

**Claim must be made NOT later than three (3) months from the date of your sixtieth (60th) birthday**