

U.S. - Belgium Agreement on Social Security Transmittal / Request / Certification

DATE OF ORIGINAL (Month/Day/Year) (/ /)	DATE(S) OF FOLLOWUP(S) (Month/Day/Year)
	1. (/ /) 2. (/ /)
TO: <input type="checkbox"/> OFFICE NATIONAL DES PENSIONS RIJKSDIENST VOOR PENSIOENEN LANDESPENSIONAMT <input type="checkbox"/> INASTI RSVZ LISVS <input type="checkbox"/> INAMI RIZIV	FROM: <input type="checkbox"/> Social Security Administration Division of International Operations P.O. Box 17769 Baltimore, MD 21235-7769 USA <input type="checkbox"/> U.S. Embassy, Brussels, Belgium

I. INFORMATION ABOUT THE CLAIM

a) Name of Worker		
b) U.S. Social Security Number	_ _ _ / _ _ / _ _ _ _	
c) Belgium Social Insurance Number		
d) Name of Applicant		
e) Address and Telephone Number of Applicant	Address	
	Telephone Number	
f) Type of Benefits Claimed	U.S.	Belgium
Retirement	<input type="checkbox"/>	<input type="checkbox"/>
Disability	<input type="checkbox"/>	<input type="checkbox"/>
Survivors	<input type="checkbox"/>	<input type="checkbox"/>
g) Date Claim Filed (Month/Day/Year)	/ /	
h) Date Benefit Elected (Month/Day/Year)	/ /	
i) Date Work Ceased (Month/Day/Year)	/ /	
j) Name and Address of the Belgian Sickness Fund (only in case of disability)		

Form SSA-2960-BE (06-01)

II. CERTIFICATION OF DATA**A. INFORMATION ABOUT THE WORKER**

Full Name at Birth				Citizenship				
Date of Birth	Date (M/D/Y)	Verified	Beginning of Incapacity	Date (M/D/Y)	Verified	Date of Death	Date (M/D/Y)	Verified
	/ /	<input type="checkbox"/>		/ /	<input type="checkbox"/>		/ /	<input type="checkbox"/>

B. INFORMATION ABOUT THE SPOUSE OR WIDOW(ER)

Full Name				Citizenship				
Date of Birth	Date (M/D/Y)	Verified	Date of Marriage	Date (M/D/Y)	Verified	Date of Divorce	Date (M/D/Y)	Verified
	/ /	<input type="checkbox"/>		/ /	<input type="checkbox"/>		/ /	<input type="checkbox"/>

Belgian Social Insurance Number of the widow:

C. INFORMATION ABOUT CHILD(REN)

Name	Date of Birth (M/D/Y)	Verified	Relationship to worker	Verified
	/ /	<input type="checkbox"/>		<input type="checkbox"/>
	/ /	<input type="checkbox"/>		<input type="checkbox"/>

III. U.S. DECISION

<input type="checkbox"/> National	<input type="checkbox"/> Art. 10	<input type="checkbox"/> None	D.O.E. (M/Y)	Monthly Benefit
			/	\$

IV. MATERIAL ATTACHED

a) Medical Evidence From The File	<input type="checkbox"/>
b) Coverage Record	<input type="checkbox"/>
c) Request For Appeal	<input type="checkbox"/>
d) Statement Regarding Income	<input type="checkbox"/>
e) No Material	<input type="checkbox"/>
f) Other (Specify)	<input type="checkbox"/>

V. INFORMATION REQUESTED

a) No Information Needed	<input type="checkbox"/>
b) Coverage Record Through (month/year) /	<input type="checkbox"/>
c) Medical Evidence From The File	<input type="checkbox"/>
d) Status of Our Request Dated / /	<input type="checkbox"/>
e) Other (See Remarks)	<input type="checkbox"/>

VI. REMARKS:

Signature	Date April 26, 2010	Stamp 
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