Form Approved
OMB No. 0960-0448
USA/LUX 3

U.S. - LUXEMBOURG AGREEMENT ON SOCIAL SECURITY
TRANSMITTAL/REQUEST/CERTIFICATION

DATE OF ORIGINAL (MONTH/DAY/YEAR)	DATE(S) OF FOLLOWUP(S) (MONTH/DAY/YEAR)	
(06/04/2012)	1. ( )	2.( )
	3.( )	4.( )

TO:	FROM:
☐ INSPECTION GENERALE DE LA SECURITE SOCIALE	☑ Social Security Administration Division of International Operations P.O. Box 17769 Baltimore ,MD 21235-7769 USA
☑ CAISSE DE PENSION DES ARTISANS DES COMMERCANTS ET INDUSTRIELS	☐ U.S. Embassy, London, England
☐ CAISSE NATIONALE D'ASSURANCE PENSION	
☐ CAISSE DE PENSIONS AGRICOLE	
☐ ETABLISSEMENT D'ASSURANCE CONTRE LA VIEILLESSE ET I'INVALIDITE	

1. INFORMATION ABOUT THE CLAIM

	First Name / (First Name)	Last Name / (Last Name)
a) Name of Worker	Tom	Jones
Name at Birth		
b) U.S. Social Security Number	/ /	
c) Luxembourg Registration Number	/ / /	
d) Name of Claimant		
Name at Birth		
e) Address of Claimant		
Telephone Number of Claimant		

f) Type of Benefits Claimed	U.S.	Luxembourg
Retirement	☐	☐
Disability	☐	☐
Survivors	☐	☐
g) Date Claim Filed (Month/Day/Year)		

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2. CERTIFICATION OF DATA

a) Date of Birth	Name (First Name) (Last Name)	Date(M/D/Y)	Verified	Monthly Benefit	Effective Date (Month/Year) (MM/yyyy)
Worker			☐	$	/
Widow(er)			☐	$	/
Child			☐	$	/
Child			☐	$	/
b) Worker's Date of Death			☐		
c) Date of Marriage			☐		
d) Date of Divorce			☐		
e) Prior Period of Disability		From (M/D/Y) to (M/D/Y)	☐		

3. INFORMATION PROVIDED

a) Coverage Record	☐
b) Medical Evidence	☐
c) Information Requested On (Month,Day,Year)	☐
d) No Information Provided	☐
e) Other - See Remarks	☐

4. INFORMATION NEEDED

a) Coverage Record	☐
b) Medical Evidence	☐
c) Status of Earlier Request (Month,Day,Year)	☐
d) No Information Provided	☐
e) Other - See Remarks	☐

5. REMARKS

test

Signature	Date	Stamp
EDWARD SCHMID	June 04, 2012	

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