REQUEST FOR RECONSIDERATION - DISABILITY CESSATION - RIGHT TO APPEAR					FOR SOCIAL SECURITY OFFICE USE ONLY (DO NOT WRITE IN THIS SPACE)				
(SEE REVERSE SIDE FOR PAPERWORK/PRIVACY ACT NOTICE)				RITY NUMBER					
NAME OF CLAIMANT SOC				KITY NUMBER					
NAME OF WAGE EARNER OR SELF-EMPLOYED PERSON (If different from Claimant)				CIAL SECURITY NUMBER					
SPOUSE'S NAME AND SOCIAL SECURITY NUMBER (COMPLETE ONLY SUPPLEMENTAL SECURITY INCOME CASE)				FO Code Benefit Continuation Foreign Language Notice					
TVDE OF		DISABILITY			SSI				
BENEFIT	TYPE OF			DISAE	SABILITY BLIND CHILD				
reasons are (reas	WITH THE DETERMINA ons should relate to the ce of the determination arlier. Include the date o	basis for stopping o	disability bene [.] ed more than	fits and be as	specific as possibl	e):			
I AM SUBMITTIN	IG THE FOLLOWING AD	DITIONAL INFORMA	ATION (If "NO	NE" write "N	ONE") (Attach addi	tional page if needed):		
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STREET ADDRESS.			REPRESEN	REPRESENTATIVE'S ADDRESS					
CITY	S	TATE ZIP CODE	CITY		ST	ATE ZIP CODE			
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	ired ONLY if this form has leration must sign below, g			mark (X), two	witnesses to the sign	I ning who know the person	on		
SIGNATURE OF WITNESS				ATURE OF WITI	NESS				
ADDRESS (NUMBER AND STREET, CITY, STATE, ZIP CODE)			ADDRESS	ADDRESS (NUMBER AND STREET, CITY, STATE, ZIP CODE)					

PRIVACY ACT AND PAPERWORK REDUCTION ACT NOTICE

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- 3. A Federal law requires that we give out this information;
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We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it.

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Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the <u>Paperwork Reduction Act of 1995</u>. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 13 minutes to read the instructions, gather the facts, and answer the questions. SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. To find the nearest office, call 1-800-772-1213 (TTY 1-800-325-0778). Send <u>only</u> comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 21235-6401.

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				RITY NUMBER				
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SPOUSE'S NAME AND SOCIAL SECURITY NUMBER (COMPLETE ONLY SUPPLEMENTAL SECURITY INCOME CASE)					FO Code Benefit Continuation Foreign Language Notice			
TYPE OF		DISABILITY			SSI			
BENEFIT WORKER WIDOW CHILD			☐ DISABILITY ☐ BLIND ☐ CHILD					
reasons are (reas	E WITH THE DETERMINA sons should relate to the ce of the determination o arlier. Include the date o	basis for stopping on your claim is date	disability benef ed more than (its and be as	specific as possible	e):		
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OR (If you	u need an interpreter, SSA v	vill provide one at no o	cost to you.)					
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CLAIMANT SIGNATURE				SIGNATURE OR NAME OF CLAIMANT'S REPRESENTATIVE				
STREET ADDRESS.			REPRESEN	REPRESENTATIVE'S ADDRESS				
CITY	S	TATE ZIP CODE	CITY		ST	ATE ZIP CODE		
TELEPHONE NUME	BER	DATE	TELEPHON	NE NUMBER		DATE		
	ired ONLY if this form has l deration must sign below, g			mark (X), two	witnesses to the sign	I ing who know the person		
1. SIGNATURE OF WITNESS				2. SIGNATURE OF WITNESS				
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SPOUSE'S NAME AND SOCIAL SECURITY NUMBER (COMPLETE ONLY SUPPLEMENTAL SECURITY INCOME CASE)				FO Code Benefit Continuation Foreign Language Notice				
TYPE OF		DISABILITY			SSI			
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NAME OF CLAIMA		1	CIAL SECURITY NUMBER					
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CHECK BLOCK 1	AND THE STATEMENT	S THAT APPLY OI	R CHECK BL	OCK 2.				
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SSA will insert the following revised Privacy Act Statement into the form at its next scheduled reprinting:

Privacy Act Statement

Sections 205(a), 1631(c)(1)(A) and (B), of the Social Security Act, as amended, authorizes the collection of information on this form. The information you provide will help us to determine your potential eligibility for benefit payments and to help us to decide if additional information is needed. Your response is voluntary. However, failure to provide the requested information may prevent an accurate and timely decision on any claim filed, or could result in the loss of benefits.

We rarely use the information provided on this form for any purpose other than for determining entitlement to benefit payments. In accordance with 5 U.S.C. § 552a(b) of the Privacy Act, however, we may disclose the information provided on this form in accordance with approved routine uses, which include but are not limited to the following:

- 1) To enable a third party or an agency to assist Social Security in establishing rights to Social Security benefits or coverage;
- 2) To comply with Federal laws requiring the release of information from Social Security records (e.g., to the Government Accountability Office and Department of Veterans Affairs);
- 3) To make determination for eligibility in similar health and income maintenance programs at the Federal, State, and local level; and,
- 4) To facilitate statistical research, audit or investigate activities necessary to ensure the integrity of Social Security programs.

We may also use the information you provide in Computer Matching programs. Matching programs compare our records with records kept by other Federal, State, or local government agencies. Information from these matching programs can be used to establish or verify a person's eligibility for Federally funded and administered benefit programs and for repayment of payment's or delinquent debts under these programs.

A complete list of routine uses for this information is available in System of Records Notice 60-0089. The notice, additional information regarding this form, and information regarding our programs and systems are available on-line at www.socialsecurity.gov or at your local Social Security office.