SOCIAL SECURITY ADMINISTRATION

Form Approved
OMB No. 0960-0349

REQUEST FOR RECONSIDERATION - DISABILITY CESSATION - RIGHT TO APPEAR

(SEE REVERSE SIDE FOR PAPERWORK/PRIVACY ACT NOTICE)

FOR SOCIAL SECURITY OFFICE USE ONLY
(DO NOT WRITE IN THIS SPACE)

NAME OF CLAIMANT	SOCIAL SECURITY NUMBER
NAME OF WAGE EARNER OR SELF-EMPLOYED PERSON (If different from Claimant)	SOCIAL SECURITY NUMBER

SPOUSE'S NAME AND SOCIAL SECURITY NUMBER (COMPLETE ONLY IN SUPPLEMENTAL SECURITY INCOME CASE)

☐ FO Code _____
☐ Benefit Continuation
☐ Foreign Language Notice _____

TYPE OF BENEFIT	DISABILITY			SSI		
	☐ WORKER	☐ WIDOW	☐ CHILD	☐ DISABILITY	☐ BLIND	☐ CHILD

I DO NOT AGREE WITH THE DETERMINATION TO STOP DISABILITY BENEFITS AND I REQUEST RECONSIDERATION. My reasons are (reasons should relate to the basis for stopping disability benefits and be as specific as possible):
NOTE: If the notice of the determination on your claim is dated more than 65 days ago, include your reason for not making this request earlier. Include the date on which you received the notice.

I AM SUBMITTING THE FOLLOWING ADDITIONAL INFORMATION (If "NONE" write "NONE") (Attach additional page if needed):

CHECK BLOCK 1 AND THE STATEMENTS THAT APPLY **OR** CHECK BLOCK 2.

☐ 1. I (and/or my representative) wish to appear at a face-to-face disability hearing. The disability hearing will be with a person called a disability hearing officer and it will let me explain why I do not agree with the decision to stop benefits.

☐ I need an interpreter at the disability hearing - Language _____
(If you need an interpreter, SSA will provide one at no cost to you.)

OR

☐ 2. I do not wish to appear nor do I wish a representative to appear for me at the disability hearing. I have been advised of my right to have a disability hearing. I understand that a disability hearing will give me a chance to present witnesses. It will also let me explain to the disability hearing officer why my disability benefits should not end. I understand that this chance to be seen and heard could help the disability hearing officer learn about the facts in my case. The disability hearing officer would give me a chance to have people who know about my condition give information and explain how my condition keeps me from working and restricts my activities. I have been told about my right to representation at the disability hearing, including representation by an attorney or other person of my choice. Although the above has been explained to me, I do not want to appear at at disability hearing, or have someone represent me at a disability hearing. I prefer to have the disability hearing officer decide my case on the evidence in my file, plus any evidence that I submit or that may be obtained by the Social Security Administration. I have been advised that if I change my mind, I can request a disability hearing prior to the writing of a decision in my case. In this case, I can make the request with any Social Security office.

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly gives a false or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime and may be sent to prison, or may face other penalties, or both.

EITHER THE CLAIMANT OR REPRESENTATIVE SHOULD SIGN - ENTER ADDRESSES FOR BOTH

CLAIMANT SIGNATURE		SIGNATURE OR NAME OF CLAIMANT'S REPRESENTATIVE	
STREET ADDRESS.		REPRESENTATIVE'S ADDRESS	
CITY STATE ZIP CODE		CITY STATE ZIP CODE	
TELEPHONE NUMBER	DATE	TELEPHONE NUMBER	DATE

Witnesses are required ONLY if this form has been signed by mark (X). If signed by mark (X), two witnesses to the signing who know the person requesting reconsideration must sign below, giving their full addresses.

1. SIGNATURE OF WITNESS	2. SIGNATURE OF WITNESS
ADDRESS (NUMBER AND STREET, CITY, STATE, ZIP CODE)	ADDRESS (NUMBER AND STREET, CITY, STATE, ZIP CODE)

See Revised Privacy Act Statement Attached

PRIVACY ACT AND PAPERWORK REDUCTION ACT NOTICE

The Privacy Act requires us to notify you that we are authorized to collect this information by sections 205(a), 1631(e)(1)(A) and (B) of the Social Security Act. You do not have to provide the information requested. However,we cannot act on your request unless you give us this information.

The Social Security Administration will use the information on this form to fully evaluate your claim for disability benefits. We may routinely give out the information on this form without your consent if:

1. We need to get more information to decide if you are eligible for benefits;

2. An agency needs this information to decide if you are eligible for a health or income program such as SSI State supplementary payments, food stamps, Medicaid, energy assistance, Veterans benefits, or Basic Educational Opportunity Grants;

3. A Federal law requires that we give out this information;

4. Your Congressman or the President's Office needs this information to answer your questions;

5. Someone needs this information to do statistical research or audit reports for us related to the Social Security programs, or,

6. The Department of Justice needs the information to represent the Federal Government in a court suit related to SSA administered programs.

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.

Explanations about these and other reasons why information you provide us may be used or given out are available in Social Security Offices. If you want to learn more about this, contact any Social Security Office.

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. 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 **only** comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 21235-6401.

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SPOUSE'S NAME AND SOCIAL SECURITY NUMBER (COMPLETE ONLY IN SUPPLEMENTAL SECURITY INCOME CASE)	

☐ FO Code _____
☐ Benefit Continuation
☐ Foreign Language Notice _____

TYPE OF BENEFIT	DISABILITY			SSI		
	☐ WORKER	☐ WIDOW	☐ CHILD	☐ DISABILITY	☐ BLIND	☐ CHILD

I DO NOT AGREE WITH THE DETERMINATION TO STOP DISABILITY BENEFITS AND I REQUEST RECONSIDERATION. My reasons are (reasons should relate to the basis for stopping disability benefits and be as specific as possible):
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CITY STATE ZIP CODE		CITY STATE ZIP CODE	
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DHU SCHEDULING

See Revised Privacy Act Statement Attached

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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.