SOCIAL SECURITY ADMINISTRATION

Request for Reinstatement - Title II

Claimant's Name	Claim Number
Wage Earner's Name	

I request reinstatement of my Social Security Disability Benefits. I am disabled and my impairment is the same as (or related to) the impairment which was the basis for my prior entitlement. I am not performing substantial gainful activity (SGA) and my medical condition prevents me from performing SGA.

I understand that I may be able to receive provisional (temporary) benefits while my request for reinstatement is being decided.

FOR INDIVIDUALS WHO HAVE EXTENDED MEDICARE COVERAGE:
I understand that my Medicare coverage (Part A hospital insurance and Part B medical insurance) could terminate if my request for reinstatement is denied.

I declare under penalty of perjury that I have examinded 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.

Signature	Date	Area Code and Telephone Number Where You Can Be Reached During the Day

Address (Number and Street)

City and State	Zip Code

WITNESSES (Write in ink)

Witnesses are required ONLY if this request has been signed by mark (x) above. If signed by mark (x), two witnesses to the signing who know the applicant must sign below, giving their full addresses.

1. Signature of Witness	2. Signature of Witness
Address (Number and Street, City, State and Zip Code)	Address (Number and Street, City, State and Zip Code)

REPRESENTATIVE PAYEE (Write in ink)

Your Title or Relationship to the Claimant	Area Code and Telephone Number Where You Can Be Reached During the Day

Address (Number, Street)

City and State	Zip Code

Your full name (First name, middle initial, last name) **Please print here**	Signature **Please sign here**	Date

Collection and Use of Information from Your Reinstatement Request
Privacy Act Notice

The Social Security Administration is authorized to collect the information on this form under section 202(b), 202(c), 202(d), 202(e), 202(f), 205(a), 223, and 1872 of the Social Security Act, as amended (42 U.S.C. 402(b), 402(c), 402(d), 402(e), 402(f), 405(a), 423, and 1395(ii)). While it is VOLUNTARY, except in the circumstances explained below, for you to furnish the information on this form to Social Security, no benefits may be paid unless a reinstatement request has been received by a Social Security office. Your response is mandatory where the refusal to disclose certain information affecting your right to payment would reflect a fraudulent intent to secure benefits not authorized by the Social Security Act. The information on this form is needed to enable Social Security to determine if you and your dependents are entitled to insurance coverage and/or monthly benefits. Failure to provide all or part of this information could prevent an accurate and timely decision on your request and could result in the loss of some benefits or insurance coverage. Although the information you furnish on this form is almost never used for any other purpose than stated in the foregoing, there is a possibility that information may be disclosed to another person or to another governmental agency as follows: 1. to enable a third party or an agency to assist Social Security in establishing rights to Social Security benefits and/or coverage; and 2. to comply with Federal laws requiring the release of information from Social Security records (e.g., to the General Accounting Office and the Department of Veterans Affairs).

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 - This information collection meets the requirement of 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 2 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. The office is listed under U.S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213 (TTY 1-800-325-0778).** *You may send comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 21235-6401.* ***Send only comments relating to our time estimate to this address, not the completed form.***