

Social Security Administration  
Retirement, Survivors, and Disability Insurance  
**Important Information**

FO Address

Date:

Claim Number:

Beneficiary name

Address

City St ZIP

We are writing to you because we need to know more about your work. Please tell us about your work since \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_. We will use this information to decide if you can receive or continue to receive disability benefits.

**What You Need To Do**

Please complete and return the completed form **within 15 days** to the address shown above. It is important to fill out the form carefully and completely. Remember to sign and date the form. If you do not return this form, we may contact your employer or make our determination based on the evidence we have in our records.

**Some Information To Help You Complete This Form**

Our records show these employers and yearly earnings for you. This list may not be complete. It may not show your work for this year or last year. You should add any additional work information as you complete the form.

<b>Employer Name</b>	<b>Year</b>	<b>Earnings</b>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

## **If You Have Questions**

If you have any questions, or need help completing the form:

- Visit us online at [www.socialsecurity.gov](http://www.socialsecurity.gov). We can answer many of your general questions online.
- Call us toll-free at 1-800-772-1213, or call your local field office at xxx-xxx-xxxx. If you are deaf or hearing impaired, our TTY toll-free number is 1-800-325-0778. We can answer most of your questions over the phone.
- Write or visit any Social Security office. The office that serves your area is located at:

*Insert local FO address*

If you live outside the United States, please contact any Social Security office or the nearest United States Embassy, or consulate. If you live in the Philippines, you may contact the Veterans Administration Regional Office, Social Security Division, 1131 Roxas Boulevard, Manila. You may also write the Social Security Administration, P.O. Box 17775, Baltimore, Maryland, 21235-7775, USA.

If you do call or visit an office, please have this letter with you. It will help us answer your questions. Also, if you plan to visit an office, please call ahead to make an appointment. This will help us serve you more quickly.

Please read the enclosed pamphlet, "Working While Disabled ... How We Can Help." It will tell you more about why we need to know about your work, and will explain our rules about working. This pamphlet is also available online at [www.ssa.gov/pubs/10095.html](http://www.ssa.gov/pubs/10095.html).

**District Manager**

Enclosures:

Form(s): ~~SSA-820-F4~~ or ~~SSA-821-BK~~

SSA Pub No. 05-10095

Pre-addressed Envelope

Form SSA-821-BK  
(mm-YYYY)

## Work Activity Report - Employee

### Identification - To Be Completed by SSA

Name of Claimant or Beneficiary	Claimant or Beneficiary's Own SSN	<input type="checkbox"/> Blind <input type="checkbox"/> Not Blind
Claim Number(s) & BIC		

Please use this form to tell us about your work activity since (Insert alleged onset date, date of onset, date of entitlement, or last determination date, as appropriate).

**DATE**

### Information - To Be Completed By Person Applying For Or Receiving Benefits

Please answer each of the questions on this form with as many details as you can. This information will help us decide if you should get or keep getting disability benefits.

If you need more room for your answers, go to the Remarks Section at the end of the form.

1. Have you had any employment income or wages since the DATE shown above in the Identification section? (check one)

- NO.** If you did not work but earnings were reported for you, go to Question 2.
- YES.** Go to Question 3.

2. If you did not work, other types of income may have been reported for you. Please complete the information below. We may ask you for proof of this income. When you are finished, go to Question 7.

Type of Payment	Name and Address of Payer	Amount	Date Received (MM/YYYY - MM/YYYY)
<input checked="" type="checkbox"/> <i>Example</i>	<i>ABC Company 123 Any Street, Your Town, MD 54321</i>	<i>\$100 per day, week, month, or year</i>	<i>01/2000 - 02/2000</i>
<input type="checkbox"/> Back Pay		\$ _____ per _____	
<input type="checkbox"/> Vacation Pay		\$ _____ per _____	
<input type="checkbox"/> Holiday Pay		\$ _____ per _____	
<input type="checkbox"/> Bonus or Commission		\$ _____ per _____	
<input type="checkbox"/> Royalties		\$ _____ per _____	
<input type="checkbox"/> Sick Pay		\$ _____ per _____	
<input type="checkbox"/> Disability Pay		\$ _____ per _____	
<input type="checkbox"/> Insurance Payment		\$ _____ per _____	
<input type="checkbox"/> Workers Compensation		\$ _____ per _____	
<input type="checkbox"/> Other (please explain)		\$ _____ per _____	

**3A.** Please tell us about your work **since the DATE shown in the Identification section, beginning with your most recent employer.** If you are not sure about this, ask your employer(s) to help you. Use the additional space provided in the Remarks section if you need more room for your answer.

<b>Current Or Most Recent Employer's Name</b>		Area Code and Telephone Number		Area Code and Fax Number	
Mailing Address			City	State	ZIP
Job Title & Type of Work					
Date Work Started (MM/YYYY)	Date Work Ended (If ended) <input type="checkbox"/> Still working (MM/YYYY)	Rate of Pay \$ _____ per _____		Hours Worked per Week (on average)	

Attach copies of all your pay stubs from this employer or ask this employer for a wage print-out showing gross monthly earnings **since the DATE shown in the Identification section.**

- I have **ENCLOSED Pay Stubs or Gross Wage Print Outs.**
- I **DO NOT have Pay Stubs or Gross Wage Print Outs.** For any months that you DO NOT have pay stubs or a print-out, use the chart below to tell us how much you earned (before deductions) in each month.

Date Earned MM/YYYY	Amount	Date Earned MM/YYYY	Amount	Date Earned MM/YYYY	Amount
	\$		\$		\$
	\$		\$		\$
	\$		\$		\$
	\$		\$		\$

**3B.** If you do not have any more employers, **go to question 4.**

<b>Previous Employer's Name</b>		Area Code and Telephone Number		Area Code and Fax Number	
Mailing Address			City	State	ZIP
Job Title & Type of Work					
Date Work Started (MM/YYYY)	Date Work Ended (If ended) <input type="checkbox"/> Still working (MM/YYYY)	Rate of Pay \$ _____ per _____		Hours Worked per Week (on average)	

Attach copies of all your pay stubs from this employer or ask this employer for a wage print-out showing gross monthly earnings **since the DATE shown in the Identification section.**

- I have **ENCLOSED Pay Stubs or Gross Wage Print Outs.**
- I **DO NOT have Pay Stubs or Gross Wage Print Outs.** For any months that you DO NOT have pay stubs or a print-out, use the chart below to tell us how much you earned (before deductions) in each month.

Date Earned MM/YYYY	Amount	Date Earned MM/YYYY	Amount	Date Earned MM/YYYY	Amount
	\$		\$		\$
	\$		\$		\$
	\$		\$		\$
	\$		\$		\$

**3C.** If you do not have any more employers, go to question 4.

<b>Previous Employer's Name</b>	Area Code and Telephone Number	Area Code and Fax Number	
Mailing Address	City	State	ZIP

Job Title or Type of Work

Date Work Started (MM/YYYY)	Date Work Ended (If ended) <input type="checkbox"/> Still working (MM/YYYY)	Rate of Pay \$ _____ per _____	Hours Worked per Week (on average)
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Attach copies of all your pay stubs from this employer or ask this employer for a wage print-out showing gross monthly earnings since the **DATE** shown in the Identification section.

- I have **ENCLOSED Pay Stubs or Gross Wage Print Outs.**
- I **DO NOT** have Pay Stubs or Gross Wage Print Outs. For any months that you DO NOT have pay stubs or a print out, use the chart below to tell us how much you earned (before deductions) in each month.

Date Earned MM/YYYY	Amount	Date Earned MM/YYYY	Amount	Date Earned MM/YYYY	Amount
	\$		\$		\$
	\$		\$		\$
	\$		\$		\$
	\$		\$		\$
If you have more employers, go to the Remarks section.					

**4.** Do or did you get any other payment(s) or benefit(s) from an employer in addition to the regular pay shown in Question 3?

- NO. Go to Question 5.**
- YES. Please check all that apply below.**
  - Sick Pay       Disability Pay       Vacation Pay       Tips       Bonus
  - Transportation       Car or Vehicle       Childcare       Meals       Room or Rent
  - Other (Please explain): \_\_\_\_\_

For each payment or item checked, tell us the employer who provided it, the amount or dollar value, and when it was received.

Payment or Item	Employer Name	Amount or Estimate of Value	Date Received (MM/YYYY - MM/YYYY)
Example: Sick Pay	ABC Company	\$100 per day, week, month, or year	01/2000-02/2000
		\$ _____ per _____	
		\$ _____ per _____	
		\$ _____ per _____	

5. For any job(s) that you told us about in Question 3, have you worked under any special conditions listed below?

Yes	Special Condition	Employer Name	Date (MM/YYYY to MM/YYYY)	Please Describe
<input type="checkbox"/>	Had extra help, extra supervision or a job coach			
<input type="checkbox"/>	Worked irregular or fewer hours than other workers			
<input type="checkbox"/>	Given special equipment because of my condition			
<input type="checkbox"/>	Took more rest periods than other workers			
<input type="checkbox"/>	Given special transportation to and from work			
<input type="checkbox"/>	Had fewer or easier duties than other workers			
<input type="checkbox"/>	Allowed to produce less work than other workers			
<input type="checkbox"/>	Hired through special training or therapy program			
<input type="checkbox"/>	Given work that was suited to my condition			
<input type="checkbox"/>	Given special help getting ready for work			
<input type="checkbox"/>	Other (explain)			
<input type="checkbox"/>	Other (explain)			
<input type="checkbox"/>	<b>None of the above apply. Go to Question 6A.</b>			

**6A.** For any job that you told us about in Question 3, did you make any of the changes below since the **DATE shown in the Identification section**. (Check all that apply).

Yes	Special Condition	Employer Name	Date (MM/YYYY)	Reasons for Changes in Work Activity
<input type="checkbox"/>	Stopped working			<input type="checkbox"/> My physical and/or mental condition(s). <input type="checkbox"/> Special conditions that helped me to work were removed. <input type="checkbox"/> Other reasons. (Please explain in 6B).
<input type="checkbox"/>	Reduced my work hours			<input type="checkbox"/> My physical and/or mental condition(s). <input type="checkbox"/> Special conditions that helped me to work were removed. <input type="checkbox"/> Other reasons. (Please explain in 6B).
<input type="checkbox"/>	Reduced my earnings			<input type="checkbox"/> My physical and/or mental condition(s). <input type="checkbox"/> Special conditions that helped me to work were removed. <input type="checkbox"/> Other reasons. (Please explain below 6B).
<input type="checkbox"/>	Changed to a lighter or easier type of work			<input type="checkbox"/> My physical and/or mental condition(s). <input type="checkbox"/> Special conditions that helped me to work were removed <input type="checkbox"/> Other reasons. (Please explain below 6B).
<input type="checkbox"/>	<b>NO</b> , I did not make any changes since the date shown in the Identification section. <b>Go to Question 7.</b>			

**6B.** Use this space to provide any additional information about your work changes.






### Signature

I authorize any employer, agency, or other organization to disclose to the Social Security Administration or the State agency that may determine or review my entitlement to disability benefits, any information about my physical and/or mental condition(s) or my work.

**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.**

Signature of Claimant, Beneficiary, or Representative	Date	Area Code and Telephone Number	
Mailing Address	City	State	ZIP

If this statement is signed by mark (e.g. X), two witnesses to the signing who know the person making the statement must sign below, giving their full addresses and telephone numbers.

1. Signature of Witness	Date	Area Code and Telephone Number	
Mailing Address	City	State	ZIP
2. Signature of Witness	Date	Area Code and Telephone Number	
Mailing Address	City	State	ZIP

### Privacy Act Statement Collection and Use of Personal Information

Sections 223 and 1632 of the Social Security Act as amended [42 U.S.C. 423 and 1383a], authorize us to collect this information. The information you provide will allow us to determine your eligibility for benefits. Your response is voluntary. However, your failure to provide all or part of the requested information could prevent us from making an accurate and timely decision on your claim and could result in the loss of benefits. We rarely use the information you provide on this form for any purpose other than for the reasons explained above. However, we may use it for the administration and integrity of Social Security programs. We may also disclose information to another person or to another agency 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 and/or coverage;
2. To comply with Federal laws requiring the release of information from Social Security records (e.g., to the Government Accountability Office, General Services Administration, National Archives Records Administration, and the Department of Veterans Affairs);
3. To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level; and
4. To facilitate statistical research, audit, or investigative activities necessary to assure 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 agencies can be used to establish or verify a person's eligibility for Federally-funded or administered benefit programs and for repayment of payments or delinquent debts under these programs.

A complete list of routine uses for this information is available in our System of Records Notice entitled, Earnings Recording and Self-Employment Income System, 60-0059. The notice, additional information regarding this form, and information regarding our system and programs, are available on-line at [www.socialsecurity.gov](http://www.socialsecurity.gov) or at any local Social Security office.

## PAPERWORK REDUCTION ACT

This information collection meets the clearance requirements of 44 U.S.C. §3507, as amended by Section 2 of the Paperwork Reduction Act of 1995. You are not required to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take you about 45 minutes to read the instructions, gather the necessary facts, and answer the questions. **SEND 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.*