Social Security Administration
Office of Quality Performance

(Address of Office)
Date:
Applicant Name:
SSN:

(Address)

(Fill-in 1) (First sentence deleted.)

In order to proceed with the review, the following is needed:

(Fill-in 2)

Please send the requested documents in the enclosed self-addressed, postage-paid envelope. We will return your documents immediately.

If you have questions about this request, contact me at 1-800-_____ between 8:00 a.m. and 4:00 p.m., Monday through Friday.

Thank you for your cooperation.

Sincerely,

Social Insurance Specialist

Enclosure(s)

PAPER REDUCTION ACT NOTICE

Paperwork Reduction Act Statement – This information collection meets the requirements of 44 U.S.C section 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. The OMB number for this collection is 0960-0066. We estimate that it will take about 15 minutes to read the instructions, gather the facts, and answer the questions. *Send **only** comments on our time estimate above to: SSA, 1338 Annex Building, Baltimore, MD 21235-0001.*