



**SOCIAL SECURITY**  
Office of Operations

Social Security Administration  
Operations Analysis Section  
1200 Rev. Abraham Woods Jr. Blvd.  
Birmingham, AL 35285-0001  
Date:  
Claim Number:

Mr. John Smith  
123 Main Street  
Baltimore, MD 21230

Dear Mr. Smith:

We are writing to you about (fill-in with your or beneficiary's name possessive) work and earnings for (fill-in with year(s)).

**Medical Resident Tax Refund Claims**

(Fill-in with You or beneficiary's name) consented for (fill-in with your, his, or her) employer to file a refund claim on (fill-in with your, his, or her) behalf. The refund claim is for Federal Insurance Contributions Act (FICA) taxes that (fill-in with your, his, or her) employer withheld from wages (fill-in with you, he, or she) earned as a medical resident for 2001 through 2004. FICA taxes are Social Security and Medicare taxes.

**A Refund Will Affect (Fill-in with Your or beneficiary name possessive) Social Security Benefits**

We will lower (fill-in with your or beneficiary name possessive) benefit amount to (fill-in with \$ amount) if (fill-in with you, he, or she) (fill-in with receive or receives) a refund of FICA taxes. If (fill-in with you or beneficiary name) (fill-in with have or has) a spouse or children receiving benefits, we will also lower their benefit amounts.

**What (Fill-in with You or Beneficiary Name) (Fill-in with Need or Needs) to Do**

Please decide whether (fill-in with you or beneficiary's name) still (fill-in with want or wants) to receive a refund of (fill-in with your, his, or her) taxes or if (fill-in with you or beneficiary name) (fill-in with wish or wishes) to withdraw (fill-in with your, his, or her) refund claim in order to keep (fill-in with your, his, or her) current benefit amount(s). Please complete, sign, and return the enclosed form SSA-795-OP2 in the enclosed envelope. It is important that (fill-in with you

or beneficiary name) return the signed form to us within 10 days of the date (fill-in with you or beneficiary name) received this letter.

### **What Will Happen**

If you decide you do not want the refund, we will share (fill-in with your or beneficiary name possessive) response with the Internal Revenue Service (IRS). Once (fill-in with you or beneficiary name) (fill-in with have or has) submitted the signed, enclosed form, no further action is required on (fill-in with your, his, or her) part. If we do not receive the form within 10 days, we will assume (fill-in with you or beneficiary name) (fill-in with want or wants) to continue with (fill-in with your, his, or her) refund claim and the IRS will pay (fill-in with you or beneficiary name) (fill-in with your, his, or her) refund, even though this will affect (fill-in with your, his, or her) benefits.

### **If (Fill-in with You or Beneficiary Name) (Fill-in with Have or Has) Questions**

If (fill-in with you or beneficiary name) (fill-in with have or has) specific questions about this letter, please call us toll-free at 1-800-254-9491 and enter extension 32240.

We invite (fill-in with you or beneficiary name) to visit our website at [www.socialsecurity.gov](http://www.socialsecurity.gov) on the Internet to find general information about Social Security. We can answer most questions over the phone. For general questions, please call us toll-free at 1-800-772-1213. (Fill in with Your or Beneficiary name possessive) local Social Security office is located at Suite 200, 1010 Park Avenue, Baltimore, MD 21201. If (fill-in with you or beneficiary name) (fill-in with are or is) deaf or hard of hearing, (fill-in with you, he, or she) may call our TTY number, 1-800-325-0778.

If (fill-in with you or beneficiary name) (fill-in with have or has) specific questions about (fill-in with your, his or her) refund, please call the IRS toll-free at 1-800-919-1703.

[Fill-in with PSC Director's Signature (ARC, PCO)]

Enclosure: Form SSA-795-OP2