



**Social Security Administration  
Office of Quality Performance**

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**(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)

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## 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.*