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.

Employer Name	Year	Earnings

If You Have Questions

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

- Visit us online at 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.

District Manager

Enclosures:
~~Form(s): SSA-820-F4 or SSA-821-BK-~~
SSA Pub No. 05-10095
Pre-addressed Envelope

Work Activity Report - Employee

Identification - To Be Completed by SSA

Name of Claimant or Beneficiary	Claimant or Beneficiary's Own SSN	☐ Blind ☐ 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)
☑ Example	ABC Company 123 Any Street, Your Town, MD 54321	$100 per day, week, month, or year	01/2000 - 02/2000
☐ Back Pay		$ _____per_____	
☐ Vacation Pay		$ _____per_____	
☐ Holiday Pay		$ _____per_____	
☐ Bonus or Commission		$ _____per_____	
☐ Royalties		$ _____per_____	
☐ Sick Pay		$ _____per_____	
☐ Disability Pay		$ _____per_____	
☐ Insurance Payment		$ _____per_____	
☐ Workers Compensation		$ _____per_____	
☐ 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.

Current Or Most Recent Employer's Name	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) (MM/YYYY) ☐ Still working	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.**

Previous Employer's Name	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) (MM/YYYY) ☐ Still working	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.**

Previous Employer's Name	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) (MM/YYYY) ☐ Still working	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
	$		$		$
	$		$		$
	$		$		$
	$		$		$
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
☐	Had extra help, extra supervision or a job coach			
☐	Worked irregular or fewer hours than other workers			
☐	Given special equipment because of my condition			
☐	Took more rest periods than other workers			
☐	Given special transportation to and from work			
☐	Had fewer or easier duties than other workers			
☐	Allowed to produce less work than other workers			
☐	Hired through special training or therapy program			
☐	Given work that was suited to my condition			
☐	Given special help getting ready for work			
☐	Other (explain)			
☐	Other (explain)			
☐	**None of the above apply. Go to Question 6A.**			

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
☐	Stopped working			☐ My physical and/or mental condition(s). ☐ Special conditions that helped me to work were removed. ☐ Other reasons. (Please explain in 6B).
☐	Reduced my work hours			☐ My physical and/or mental condition(s). ☐ Special conditions that helped me to work were removed. ☐ Other reasons. (Please explain in 6B).
☐	Reduced my earnings			☐ My physical and/or mental condition(s). ☐ Special conditions that helped me to work were removed. ☐ Other reasons. (Please explain below 6B).
☐	Changed to a lighter or easier type of work			☐ My physical and/or mental condition(s). ☐ Special conditions that helped me to work were removed ☐ Other reasons. (Please explain below 6B).
☐	**NO,** I did not make any changes since the date shown in the Identification section. **Go to Question 7.**			

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

7. Do or did you have to spend any of your own money for items or services **related to your physical and/or mental condition(s)** that you needed in order to work and for which you did not get reimbursed? (For example: medicines or co-pays, medical devices or procedures, Braille equipment, special telephone or equipment, service animal, attendant care, modifications to a car used for work, or other special transportation.) We may ask you for proof of payment.

☐ **NO,** I did not spend any of my own money for items or services related to my physical and/or mental condition.

☐ **YES.** Please tell us what you paid below. Do not show any expenses that have been or will be paid by an insurance company, other organization, or other person.

Describe Item or Service	Cost	Date Paid (MM/YYYY - MM/YYYY)
Example: Service animal	$100 per day, week, month, or year	01/2000 - 02/2000
	$_____ per _____	
	$_____ per _____	
	$_____ per _____	
	$_____ per _____	

Remarks

Use this section to add any information you did not have space for in other parts of the form. Please show the number of the question you are answering.

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

See Revised Privacy Act Statement

Sections 223 and 1632 of the Social Security Act as amended [42 U.S.C. 423 and 1383a], authorize us to collect th n you provide will allow us to determine your eligibility for benefits. Your response is voluntary. However, your failure to 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** or at any local Social Security office.

See Revised Paperwork Reduction Act

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.***

SSA will insert the following revised PRA Statement into the form at its next scheduled reprinting:

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 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 (OMB) control number. The OMB control number for this collection is 0960-0059. We estimate that it will 40 minutes to read the instructions, gather the facts, and answer the questions. ***Send only comments relating to our time estimate above to***: *SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.*