

WAIVER OF RIGHT TO APPEAR--DISABILITY HEARING

(DO NOT WRITE IN THIS SPACE)

Paperwork/Privacy Act Notice: The Social Security Administration is authorized to collect the information on this form under sections 205(a), 1631(e)(1)(A) and (B), and 1872 of the Social Security Act, as amended (42 U.S.C. 405, 1383 and 1395ii). Giving us the information on this form is voluntary. However, if you do not respond, we will be unable to act on your request to waive your right to appear at a disability hearing. The Social Security Administration will use the information on this form to fully evaluate your claim for disability benefits. We may routinely give out the information on this form without your consent if:

1. A Federal law requires that we give out this information;
2. Your Congressman or the President's Office needs this information to answer questions you ask them;
3. Someone needs this information to do statistical research or audit reports for us related to the Social Security programs, or,
4. The Department of Justice needs the information to represent the Federal Government in a court suit related to SSA administered programs.

Explanations about these and other reasons why information you provide us may be used or given out are available in Social Security Offices. If you want to learn more about this, contact any Social Security Office.

NAME OF CLAIMANT

NAME OF WAGE EARNER OR SELF-EMPLOYED

SOCIAL SECURITY NUMBER

SPOUSE'S NAME AND SOCIAL SECURITY NUMBER (COMPLETE **ONLY** IN SUPPLEMENTAL SECURITY INCOME CASE)

TYPE OF BENEFIT	DISABILITY			SSI		
	<input type="checkbox"/> WORKER	<input type="checkbox"/> WIDOW/ WIDOWER	<input type="checkbox"/> CHILD	<input type="checkbox"/> DISABILITY	<input type="checkbox"/> BLIND	<input type="checkbox"/> CHILD

NAME OF REPRESENTATIVE, IF ANY

REPRESENTATIVE'S ADDRESS

TELEPHONE NUMBER (INCLUDE AREA CODE)

I have been advised of my right to have a disability hearing. I understand that a hearing will give me an opportunity to present witnesses and explain in detail to the disability hearing officer, who will decide my case, the reasons why my disability benefits should not end. I understand that this opportunity to be seen and heard could be effective in explaining the facts in my case, since the disability hearing officer would give me an opportunity to present and question witnesses and explain how my impairments prevent me from working and restrict my activities. I have been given an explanation of my right to representation, including representation at a hearing by an attorney or other person of my choice.

Although the above has been explained to me, I do not want to appear at a disability hearing, or have someone represent me at a disability hearing. I prefer to have the disability hearing officer decide my case on the evidence of record plus any evidence which I may submit or which may be obtained by the Social Security Administration. I have been advised that if I change my mind, I can request a hearing prior to the writing of a decision in my case. In this event, I can make the request with any Social Security office.

SIGNATURE (FIRST NAME, MIDDLE INITIAL, LAST NAME) (WRITE IN INK)

DATE (MONTH, DAY, YEAR)

**SIGN
HERE** 

TELEPHONE NUMBER (INCLUDE AREA CODE)

MAILING ADDRESS (NUMBER AND STREET, APT. NO., P.O. BOX, OR RURAL ROUTE)

CITY AND STATE

ZIP CODE

Witnesses are required ONLY if this form has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the person requesting reconsideration must sign below, giving their full addresses.

1. SIGNATURE OF WITNESS

2. SIGNATURE OF WITNESS

ADDRESS (NUMBER AND STREET, CITY, STATE, ZIP CODE)

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