Form Approved
OMB No 0960-0744

SOCIAL SECURITY ADMINISTRATION

Request for Reinstatement - Title XVI

Eligible Individual	SSN
Eligible Spouse	SSN

I request reinstatement of my Supplemental Security Income (SSI) Disability benefits. I am blind or disabled and my impairment is the same as (or related to) the impairment which was the basis for my prior eligibility. I meet the non-medical requirements for SSI. I am not performing substantial gainful activity (SGA) and my medical condition prevents me from performing SGA.

I understand that I may be able to receive provisional (temporary) payments while my request for reinstatement is being decided.

For persons who are entitled to any other SSA benefits based on disability or blindness:

I understand that if SSA denies my request for reinstatement because I have medically improved, my current entitlement to SSA benefits will be reviewed and may terminate.

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	Date	Area Code and Telephone Number Where You Can Be Reached During the Day

Address (Number and Street)

City and State	ZIP Code

WITNESSES (Write in ink)

This request does not ordinarily have to be witnessed. If, however, you have signed by mark (x), two witnesses to the signing who know you must sign below giving their full addresses.

1. Signature of Witness	2. Signature of Witness
Address (Number and Street, City, State and ZIP Code)	Address (Number and Street, City, State and ZIP Code)

THIS INFORMATION IS ONLY NEEDED IF YOUR PROVISIONAL BENEFITS WILL BE SENT TO YOUR PRIOR REPRESENTATIVE PAYEE
REPRESENTATIVE PAYEE (Write in ink)

Your Title or Relationship to the Recipient	Area Code and Telephone Number Where You Can Be Reached During the Day
Address (Number, Street)	
City and State	ZIP Code

Your full name (First name, middle initial, last name) **Please print here**	Signature **Please sign here**	Date

Collection and Use of Personal Information

Section 1631(e) of the Social Security Act, as amended (42 U.S.C. § 1383(e)), authorize us to collect the information requested on this form. The information you provide will be used to make a decision on this claim. Your response is voluntary. However, failure to provide the requested information may prevent an accurate and timely decision on any claim filed, or could result in the loss of benefits.

We rarely use the information provided on this form for any purpose other than for determining entitlement to Supplemental Security Income (SSI) payments. We may, however, disclose the information provided on this form in accordance with approved routine uses of the Privacy Act (5 U.S.C. § 552a(b)), which include but are not limited to the following:

1. To enable an agency or third party to assist Social Security in establishing rights to SSI payments;

2. To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level;

3. To comply with Federal laws requiring the disclosure of the information from our records; and,

4. To facilitate statistical research, audit, or investigative activities necessary to assure the integrity of SSA programs.

We may also use the information you provide when we match records by computer. Computer matching programs compare our records with those of other Federal, State, or local government agencies. Information from these matching programs 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.

Additional information regarding this form and our other system of records notices and Social Security programs are available from our Internet website at www.socialsecurity.gov or at your local Social Security office.

Paperwork Reduction Act - This information collection meets the requirement of 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 control number. We estimate that it will take about 2 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING 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.***