Social Security Administration

Form Approved
OMB No. 0960-0351

NOTICE REGARDING SUBSTITUTION OF PARTY UPON DEATH OF CLAIMANT RECONSIDERATION OF DISABILITY CESSATION

PRIVACY ACT NOTICE: The collection of information by use of this form is authorized by regulation 20 CFR 404.907-404.921 and 416.1407-416.14.21. While your responses are voluntary, we cannot act on your request without this information. Information you furnish may be disclosed by the Social Security Administration to another person or government agency only with respect to Social Security programs and to comply with Federal laws requiring disclosure or exchange of information between SSA and other government agencies.

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it.

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.

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 5 minutes to read the instructions, gather the necessary facts, and answer the questions.

NAME OF DECEASED CLAIMANT	CLAIM FOR
WAGE EARNER'S NAME (LEAVE BLANK IF SAME AS ABOVE)	SOCIAL SECURITY NUMBER

I have been informed that the claimant had requested reconsideration of a disability cessation but died before action on the request was completed. I understand that the deceased claimant's request for reconsideration of disability cessation may not be processed unless an eligible person is substituted. My relationship to the deceased claimant:

☐ WIDOW/WIDOWER ☐ SURVIVING DIVORCED SPOUSE

If you have checked either of the above boxes and have in your care the deceased's child (children) who is (are) under age 18 (or an eligible student) or disabled, check here ☐

☐ CHILD ☐ DISABLED CHILD ☐ PARENT ☐ ADMINISTRATOR/ EXECUTOR OF ESTATE ☐ OTHER (DESCRIBE) _____

COMPLETE EITHER 1 OR 2

☐ 1. I wish to be made a substitute party and to proceed with the reconsideration of a disability cessation requested by the deceased.

CHECK EITHER a, b, OR c.

If the Social Security Administration decides that a hearing is necessary:

☐ a. I want to come to the disability hearing in person as already scheduled

☐ b. I want to come to a hearing in person but request a later time or different location (specify number of days, location desired)

☐ c. I do not want to come to a hearing in person, and I request a decision on the evidence of record.

☐ 2. I do not wish to proceed with the reconsideration of a disability cessation requested by the deceased, and I hereby request withdrawal of the deceased's request for reconsideration of a disability cessation. I have had a full explanation of the effects of a withdrawal.

SIGNATURE (FIRST NAME, MIDDLE INITIAL, LAST NAME)	DATE (MONTH, DAY, YEAR)
Sign Here ▷	TELEPHONE NUMBER (INCLUDE AREA CODE)

PRINT OR TYPE FULL NAME

MAILING ADDRESS (NUMBER AND STREET ADDRESS, P.O. BOX OR RURAL ROUTE)

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