SOCIAL SECURITY ADMINISTRATION/OFFICE OF DISABILITY ADJUDICATION AND REVIEW

REQUEST TO WITHDRAW A HEARING REQUEST

Do not write in this space

IMPORTANT NOTICE - This is a request to withdraw your hearing request. The Administrative Law Judge (ALJ) will consider this request and decide if dismissing your hearing request is appropriate. If we deny your request, the hearing process will go on as if you had not filed this form. If we approve this request, the hearing process will stop. We will send you a dismissal notice and we will not process your case. The last determination in your case will stay in effect. If you change your mind, you must ask the ALJ to cancel this request to withdraw within 60 days after you get the dismissal notice. You must give a good reason why the dismissal was wrong. You may also file an appeal with the Appeals Council (AC) within 60 days after you get the dismissal notice. Even if you do not ask the ALJ to cancel your request, and do not file an appeal, the AC may set aside the dismissal of your hearing request. This would occur within 60 days after we mail the dismissal notice to you.

CLAIMANT NAME	**CLAIMANT SSN** ###-##-####
WAGE EARNER NAME, IF DIFFERENT ***(or, if applicable, name of surviving eligible spouse or other individual eligible to receive benefits due a deceased claimant)***	**CLAIMANT CLAIM NUMBER, IF DIFFERENT** ###-##-####

PRINT YOUR NAME ***(First name, middle initial, last name)***	**DATE OF HEARING REQUEST** **TYPE OF CLAIM(S)**	**BENEFIT APPLIED FOR**

I wish to withdraw my hearing request. My request is voluntary. I understand the effects of this request. Namely, an ALJ may dismiss my hearing request. If the ALJ does, the last determination in my case will stay in effect, unless the dismissal is set aside. This may result in the potential loss of benefits. I understand that I have 60 days from when I get the dismissal notice to cancel my request or file an appeal with the Appeals Council. My decision affects no other potential parties to my knowledge. I understand that all items relating to my claim will be part of SSA's records.

Give reason for withdrawal. ***(If you need more space, use the reverse of this form.)***

☐ Continued on reverse

SIGNATURE OF PERSON MAKING REQUEST (OPTIONAL)

Signature *(First name, middle initial, last name) (Write in ink)* **SIGN HERE** ▶	Date *(Month, day, year)* Telephone Number *(Include area code)*

Mailing Address *(Number And Street, Apt. No., PO Box, Or Rural Route)*

City and State	ZIP Code	Enter Name of County (if any) in which you now live

Witnesses are required ONLY if this request has been signed by a mark (X) above. If signed by a mark (X), two witnesses to the signing, who know the person making the request, must sign below. Both witnesses must give their full address.

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

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SSN: _____

Additional Remarks:

Will add Privacy Act information once the form is formally approved.

FOR USE OF SOCIAL SECURITY ADMINISTRATION

☐ APPROVED	☐ NOT APPROVED BECAUSE →	☐ CLAIMANT DOES NOT UNDERSTAND CONSEQUENCES	☐ WITHDRAWAL WOULD HARM INTEREST OF CLAIMANT OR OTHER PARTIES	☐ OTHER *(Attach explanation)*

SIGNATURE OF SSA EMPLOYEE	TITLE	DATE
	☐ ADMINISTRATIVE LAW JUDGE ☐ OTHER (Specify)	

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