SOCIAL SECURITY ADMINISTRATION/OFFICE OF DISABILITY ADJUDICATION AND REVIEW

REQUEST TO WITHDRAW AN APPEALS COUNCIL REQUEST FOR REVIEW

Do not write in this space

IMPORTANT NOTICE – This is a request to withdraw your request for review at the Appeals Council (AC). The AC will consider this request and decide if dismissing your request for review is appropriate. If the AC denies this request, the appeals process will go on as if you had not filed this form. If the AC approves this request, the appeals process will stop. The Administrative Law Judge decision will stay in effect. The dismissal of the request for review is final and cannot be appealed.

1. CLAIMANT NAME	**CLAIMANT SSN** ###-##-####
2. WAGE EARNER NAME, IF DIFFERENT ***(or, if applicable, name of surviving eligible spouse or other individual eligible to receive benefits due a deceased claimant)***	**3. CLAIMANT CLAIM NUMBER, IF DIFFERENT** ###-##-####
4. PRINT YOUR NAME ***(First name, middle initial, last name)***	**5. DATE APPEALS COUNCIL REVIEW REQUESTED** **6. DATE OF ALJ DECISION**

I wish to withdraw my request for review. My request is voluntary. I understand the effects of this request. Namely, the Appeals Council may dismiss my request for review. If it does, the Administrative Law Judge decision will stay in effect. This may result in the potential loss of benefits. The Appeals Council's dismissal of this request for review is final and cannot be appealed. 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)

FOR USE OF SOCIAL SECURITY ADMINISTRATION

SSN: _____

Additional Remarks:

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