WAIVER OF RIGHT TO APPEAR - DISABILITY HEARING

(DO NOT WRITE IN THIS SPACE)

NAME OF CLAIMANT

NAME OF WAGE EARNER OR SELF-EMPLOYED	SOCIAL SECURITY NUMBER

(COMPLETE **ONLY** IN SUPPLEMENTAL SECURITY INCOME CASE)

NAME OF SPOUSE	SOCIAL SECURITY NUMBER

TYPE OF BENEFIT	DISABILITY			SSI		
	☐ WORKER	☐ WIDOW/ WIDOWER	☐ CHILD	☐ DISABILITY	☐ BLIND	☐ 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)	ADDRESS (NUMBER AND STREET,CITY,STATE,ZIP CODE)

Privacy Act Statement
Collection and Use of Personal Information

Sections 205(a), 1631(e)(1)(A) and (B), and 1872 of the Social Security Act, as amended, authorize us to collect the information on this form. We will use the information you provide to act on your request to waive your right to appear at a disability hearing.

Your response is voluntary. However, failing to provide us with all or part of the information could result in our inability to act on your waiver request.

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

1. To enable a third party or an agency to assist Social Security in establishing rights to Social Security benefits and/or coverage;

2. To comply with Federal laws requiring the release of information from Social Security records (e. g., to the Government Accountability Office and Department of Veterans' Affairs);

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

4. To facilitate statistical research, audit, or investigative activities necessary to assure the integrity and improvement of Social Security programs.

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

A complete list of routine uses for this information is available in our System of Records Notices entitled, Claims Folders Systems (60-0089) and Administrative Law Judge Working File on Claimant Cases (60-0005). These notices, additional information regarding this form, and information regarding our programs and systems, are available on-line at http://www.socialsecurity.gov or at your local Social Security office.

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 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 15 minutes to read the instructions, gather the facts, and answer the questions. **SEND 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.***