SOCIAL SECURITY ADMINISTRATION
OFFICE OF DISABILITY ADJUDICATION AND REVIEW

Form Approved
OMB No. 0960-0710

REQUEST TO WITHDRAW A HEARING REQUEST

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.

Do not write in this space

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** / **BENEFIT APPLIED FOR**
	TYPE OF CLAIM(S)

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)*	*Date (Month, day, year)*
SIGN HERE	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)

SSN:

Additional Remarks:

FOR USE OF SOCIAL SECURITY ADMINISTRATION

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

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

Privacy Act Statement
Collection and Use of Personal Information

Sections 205 and 1631(d)(1) of the Social Security Act, as amended, allow us to collect this information. We will use the information you provide to decide if dismissing your hearing request is appropriate.

Furnishing us this information is voluntary. However, failing to provide us with all or part of the information may not allow us to make a correct determination regarding your request to withdraw your hearing request.

We rarely use the information you supply for any purpose other than to decide if dismissing your hearing is appropriate. However, we may use the information for the administration of our programs including sharing information:

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

2. To facilitate statistical research, audit, or investigative activities necessary to assure the integrity and improvement of our programs (e.g., to the Bureau of the Census and to private entities under contract with us).

A complete list of when we may share your information with others, called routine uses, is available in our Privacy Act System of Records Notices 60-0005, entitled, Administrative Law Judge Working File on Claimant Cases and 60-0009, entitled, Hearings and Appeals Case Control System. Additional information about these and other system of records notices and our programs are available from our Internet website at www.socialsecurity.gov or at your local Social Security office.

We may share the information you provide to other health agencies through computer matching programs. Matching programs compare our records with records kept by other Federal, State, or local government agencies. We use the information from these programs to establish or verify a person's eligibility for federally funded or administered benefit programs and for repayment of incorrect payments or delinquent debts under these programs.

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 (OMB) control number. We estimate that it will take about 10 minutes to read the instructions, gather the facts, and answer the questions. ***Send only comments relating to our time estimate above to***: *SSA*, *6401 Security Blvd, Baltimore, MD 21235-6401.*