**REQUEST FOR RECONSIDERATION - DISABILITY CESSATION RIGHT TO APPEAR**
(SEE REVERSE SIDE FOR PAPERWORK/PRIVACY ACT NOTICE)

FOR SOCIAL SECURITY OFFICE USE ONLY **(DO NOT WRITE IN THIS SPACE)**

| NAME OF CLAIMANT | SOCIAL SECURITY NUMBER |
|---|---|
| **NAME OF WAGE EARNER OR SELF-EMPLOYED PERSON (If different from Claimant)** | SOCIAL SECURITY NUMBER |
| SPOUSE'S NAME AND SOCIAL SECURITY NUMBER (COMPLETE ONLY IN SUPPLEMENTAL SECURITY INCOME CASE) | |

☐ FO Code _____
☐ Benefit Continuation
☐ Foreign Language Notice _____

| **TYPE OF BENEFIT** | DISABILITY | | | SSI | | |
|---|---|---|---|---|---|---|
| | ☐ WORKER | ☐ WIDOW | ☐ CHILD | ☐ DISABILITY | ☐ BLIND | ☐ CHILD |

**I DO NOT AGREE WITH THE DETERMINATION TO STOP DISABILITY BENEFITS AND I REQUEST RECONSIDERATION.**

My reasons are (reasons should relate to the basis for stopping disability benefits and be as specific as possible):
**NOTE**: If the notice of the determination on your claim is dated more than 65 days ago, include your reason for not making this request earlier. Include the date on which you received the notice.

**I AM SUBMITTING THE FOLLOWING ADDITIONAL INFORMATION** (If "NONE" write "NONE")
(Attach additional page if needed):

**CHECK BLOCK 1 AND THE STATEMENTS THAT APPLY OR CHECK BLOCK 2.**

☐ 1. **I (and/or my representative) wish to appear** at a ~~face-to-face~~ disability hearing. The disability hearing will be with a person called a disability hearing officer and it will let me explain why I do not agree with the decision to stop benefits.
☐ I need an interpreter at the disability hearing - Language _____
(If you need an interpreter, SSA will provide one at no cost to you.)

**OR**

☐ 2. **I do not wish to appear nor do I wish a representative to appear for me** at the disability hearing. I have been advised of my right to have a disability hearing. I understand that a disability hearing will give me a chance to present witnesses. It will also let me explain to the disability hearing officer why my disability benefits should not end. I understand that this chance to be seen and heard could help the disability hearing officer learn about the facts in my case. The disability hearing officer would give me a chance to have people who know about my condition give information and explain how my condition keeps me from working and restricts my activities. I have been told about my right to representation at the disability hearing, including representation 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 in my file, plus any evidence that I submit or that may be obtained by the Social Security Administration. I have been advised that if I change my mind, I can request a disability hearing prior to the writing of a decision in my case. In this case, I can make the request with any Social Security office.

**I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly gives a false or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime and may be sent to prison, or may face other penalties, or both.**

**EITHER THE CLAIMANT OR REPRESENTATIVE SHOULD SIGN - ENTER ADDRESSES FOR BOTH**

| CLAIMANT SIGNATURE | | | SIGNATURE OR NAME OF CLAIMANT'S REPRESENTATIVE | | |
|---|---|---|---|---|---|
| STREET ADDRESS. | | | REPRESENTATIVE'S ADDRESS | | |
| CITY | STATE | ZIP CODE | CITY | STATE | ZIP CODE |
| TELEPHONE NUMBER | DATE | | TELEPHONE NUMBER | DATE | |

**Witnesses are required ONLY if this form has been signed by mark (X). 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 AND PAPERWORK REDUCTION ACT NOTICE

Sections 205(a), (b), 1631(c)(1)(A) and (B), of the Social Security Act, as amended, allow us to collect this information. We will use the information you provide to determine your eligibility for disability benefits.

See Revised Privacy Act Statement Attached

Furnishing us this information is voluntary. However, failure to provide us with all or part of the information may prevent us from re-evaluating the decision on your claim.

We rarely use the information you supply for any purpose other than what we state above, 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 record (e.g., to the Government Accountability Office and Department of Veterans Affairs);and,

2. To facilitate statistical research, audit, or investigative activities necessary to ensure 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, 60-0009, entitled Hearings and Appeals Case Control System, 60-0010, entitled Hearing Office Tracking System of Claimant Cases, and 60-0089, entitled Claims Folders Systems. 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 also use the information you provide in computer matching programs. Matching programs compare our records with records kept by other Federal, State, or local government agencies. Information from these matching programs can be used 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.

**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. The OMB control number for this collection is 0960-0349. We estimate that it will take about 13 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. You can find your local Social Security office through SSA's website at www.socialsecurity.gov. Offices are also 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 21235-0001.* ***Send only comments relating to our time estimate to this address, not the completed form.***