SOCIAL SECURITY ADMINISTRATION TOE 710

FORM APPROVED
OMB NO. 0960-0534

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)

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) and (b) and 1631(e)(1)(A) and (B) of the Social Security Act, as amended, authorize us to collect this information. We will use the information you provide to acknowledge your waiver of right to appear at a disability hearing.

Furnishing us this information is voluntary. However, failing to provide us with all or part of the information may prevent an accurate and timely decision on your waiver request.

We rarely use the information you supply us for any purpose other than to make a determination regarding waiver eligibility. 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 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 60-0089, entitled Claims Folders Systems and 60-0005, entitled Administrative Law Judge Working File on Claimant Cases. Additional information about these and other system of records notices and our programs are available online 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 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.***