# Social Security Administration
# Retirement, Survivors, and Disability Insurance
## Important Information

FO Address:

Date:

BNC#:

We are writing to you because we need to know more about your work. Please tell us about your work since . We will use this information to decide if you can receive or continue to receive disability benefits.

**What You Need To Do**

Please complete and return the completed form **within 15 days** to the address shown above. It is important to fill out the form carefully and completely. Remember to sign and date the form. If you do not return this form, we may contact your employer or make our determination based on the evidence we have in our records.

**Some Information To Help You Complete This Form**

Our records show these employers and yearly earnings for you. This list may not be complete. It may not show your work for this year or last year. You should add any additional work information as you complete the form.

| Employer Name | Year | Earnings |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

## For More Information

Please read the enclosed pamphlet, “Working While Disabled: How We Can Help.” It will tell you more about why we need to know about your work, and will explain our rules about working. This pamphlet is also available online at www.ssa.gov/pubs/10095.html.

## Suspect Social Security Fraud?

If you suspect Social Security fraud, please visit https://oig.ssa.gov/report or call the Inspector General's Fraud Hotline at **1-800-269-0271** (TTY **1-866-501-2101**).

## If You Have Questions

If you have any questions, or need help completing the form:

- Visit our website at www.socialsecurity.gov to find general information about Social Security.
- Call us toll-free at 1-800-772-1213, or call your local office at . You may also call your Social Security contact, at . We can answer most questions over the phone.
- Write or visit any Social Security office. If you plan to visit an office, you may call ahead to make an appointment. The office that serves your area is located at:

- If you are deaf or hard of hearing, our toll-free TTY number is 1-800-325-0778.
- If you live outside the United States, please contact any Social Security office or the nearest United States Embassy or consulate. If you live in the Philippines, you may contact the Veterans Administration Regional Office, Social Security Division, 1131 Roxas Boulevard, Manila. You may also write to the Social Security Administration, P.O. Box 17775, Baltimore, Maryland, 21235-7775, USA.

Please have this letter with you if you call or visit an office. If you write, please include a copy of this letter. It will help us answer your questions.

**Social Security Administration**

Enclosures:
SSA Pub No. 05-10095
Pre-addressed Envelope

# Work Activity Report - Employee

Identification - To Be Completed by SSA

| Name of Claimant or Beneficiary | Claimant or Beneficiary's Own SSN | ☐ Blind<br>☐ Not Blind |
|---|---|---|

Claim Number(s) & BIC

| Please use this form to describe your work activity since **(Insert alleged onset date, date of entitlement, or last determination date, as appropriate)** | **DATE** |
|---|---|

## Information - To Be Completed By Person Applying For Or Receiving Benefits

**Please answer each of the questions on this form with as many details as you can. This information will help us decide if you should get or keep getting disability benefits.**

**If you need more room for your answers, go to the Remarks section at the end of the form.**

**1.** Have you had any employment income or wages since the DATE shown above in the Identification section? (check one)

☐ **NO. If you did not work but income was reported for you, go to Question 2.**

☐ **YES. Go to Question 3.**

**2**. If you did not work, other types of income may have been reported for you. Please complete the information below. We may ask you for proof of this income. When you are finished, **go to Question 7**.

| Type of Payment | Name and Address of Payer | Amount | Date Worked (MM/YYYY-MM/YYYY) |
|---|---|---|---|
| ☑ Example | ABC Company<br>123 Any Street<br>Your Town, MD 54321 | $100 per day, week, month, or year | 01/2000 - 02/2000 |
| ☐ Back Pay | | $_____ per_____ | |
| ☐ Vacation Pay | | $_____ per_____ | |
| ☐ Holiday Pay | | $_____ per_____ | |
| ☐ Bonus or Commission | | $_____ per_____ | |
| ☐ Royalties | | $_____ per_____ | |
| ☐ Sick Pay | | $_____ per_____ | |
| ☐ Disability Pay | | $_____ per_____ | |
| ☐ Insurance Payment | | $_____ per_____ | |
| ☐ Workers Comp | | $_____ per_____ | |
| ☐ Other (Please explain) | | $_____ per_____ | |

Claim #: _____

**3A**. Please tell us about your work **since the DATE shown in the Identification section, beginning with your most recent employer**. If you are not sure about this, ask your employer(s) to help you. Use the additional space provided in the Remarks section if you need more room for your answer.

| **Current or Most Recent Employer's Name** | Supervisor's Name | Supervisor's Telephone No. (*Include area code*) |
|---|---|---|
| | | |

| Mailing address | City | State | ZIP Code |
|---|---|---|---|
| | | | |

Job Title and Type of Work

| Date Work Started (MM/DD/YYYY) | Date Work Ended (if ended) (MM/DD/YYYY) ☐ Still working | Rate of Pay $ _____ per _____ | Hours Worked per Week (on average) |
|---|---|---|---|
| | | | |

Attach copies of all your pay stubs from this employer or ask the employer for a wage print-out showing gross monthly earnings **since the DATE shown in the Identification section.**

☐ I have **ENCLOSED Pay Stubs or Gross Wage Print Outs.**

☐ I **DO NOT have Pay Stubs or Gross Wage Print Outs.** For any months that you DO NOT have pay stubs or a print-out, use the chart below to tell us how much you earned (before deductions) in each month.

| Date Earned MM/YYYY | Amount | Date Earned MM/YYYY | Amount | Date Earned MM/YYYY | Amount |
|---|---|---|---|---|---|
| | $ | | $ | | $ |
| | $ | | $ | | $ |
| | $ | | $ | | $ |
| | $ | | $ | | $ |

**3B**. If you do not have any more employers, **go to Question 4.**

| **Previous Employer's Name** | Supervisor's Name | Supervisor's Telephone No. (*Include area code*) |
|---|---|---|
| | | |

| Mailing address | City | State | ZIP Code |
|---|---|---|---|
| | | | |

Job Title and Type of Work

| Date Work Started (MM/DD/YYYY) | Date Work Ended (if ended) (MM/DD/YYYY) ☐ Still working | Rate of Pay $ _____ per _____ | Hours Worked per Week (on average) |
|---|---|---|---|
| | | | |

Attach copies of all your pay stubs from this employer or ask the employer for a wage print-out showing gross monthly earnings **since the DATE shown in the Identification section.**

☐ I have **ENCLOSED Pay Stubs or Gross Wage Print Outs.**

☐ I **DO NOT have Pay Stubs or Gross Wage Print Outs.** For any months that you DO NOT have pay stubs or a print-out, use the chart below to tell us how much you earned (before deductions) in each month.

| Date Earned MM/YYYY | Amount | Date Earned MM/YYYY | Amount | Date Earned MM/YYYY | Amount |
|---|---|---|---|---|---|
| | $ | | $ | | $ |
| | $ | | $ | | $ |
| | $ | | $ | | $ |
| | $ | | $ | | $ |

Claim #: _____

**3C**. If you do not have any more employers, **go to Question 4.**

| **Previous Employer's Name** | Supervisor's Name | Supervisor's Telephone No. (*Include area code*) |
|---|---|---|
| | | |

| Mailing address | City | State | ZIP Code |
|---|---|---|---|
| | | | |

Job Title and Type of Work

| Date Work Started (MM/DD/YYYY) | Date Work Ended (if ended) (MM/DD/YYYY) ☐ Still working | Rate of Pay $ _____ per _____ | Hours Worked per Week (on average) |
|---|---|---|---|
| | | | |

Attach copies of all your pay stubs from this employer or ask the employer for a wage print-out showing gross monthly earnings **since the DATE shown in the Identification section.**

☐ I have **ENCLOSED Pay Stubs or Gross Wage Print Outs.**

☐ I **DO NOT have Pay Stubs or Gross Wage Print Outs.** For any months that you DO NOT have pay stubs or a print-out, use the chart below to tell us how much you earned (before deductions) in each month.

| Date Earned MM/YYYY | Amount | Date Earned MM/YYYY | Amount | Date Earned MM/YYYY | Amount |
|---|---|---|---|---|---|
| | $ | | $ | | $ |
| | $ | | $ | | $ |
| | $ | | $ | | $ |
| | $ | | $ | | $ |

If you have more employers, **go to the Remarks Section.**

**4**. Do or did you get any other payment(s) or benefit(s) from an employer **in addition to the regular pay** shown in Question 3?

☐ **NO. Go to Question 5.**

☐ **YES. Please check all that apply below.**

☐ Sick Pay ☐ Disability Pay ☐ Vacation Pay ☐ Tips ☐ Bonus

☐ Transportation ☐ Car or Vehicle ☐ Childcare ☐ Meals ☐ Room or Rent

☐ Other (Please explain): _____

| Payment or Item | Employer Name | Amount or Estimate of Value | Date Received (MM/YYYY-MM/YYYY) |
|---|---|---|---|
| Example: *Sick Pay* | *ABC Company* | *$100 per day, week, month, or year* | *01/2000 - 02/2000* |
| | | $_____ per_____ | |
| | | $_____ per_____ | |
| | | $_____ per_____ | |

Claim #: _____

**5**. For any job(s) that you told us about in Question 3, have you worked under any special conditions listed below?

| Yes | Special Condition | Employer Name | Date (MM/YYYY to MM/YYYY) | Please Describe |
|---|---|---|---|---|
| ☐ | Had extra help, extra supervision or a job coach | | | |
| ☐ | Worked irregular or fewer hours than other workers | | | |
| ☐ | Given special equipment because of my condition | | | |
| ☐ | Took more rest periods than other workers | | | |
| ☐ | Given special transportation to and from work | | | |
| ☐ | Had fewer or easier duties than other workers | | | |
| ☐ | Allowed to produce less work than other workers | | | |
| ☐ | Hired through special training or therapy program | | | |
| ☐ | Given work that was suited to my condition | | | |
| ☐ | Given special help getting ready for work | | | |
| ☐ | Other (explain) | | | |
| ☐ | Other (explain) | | | |
| ☐ | **None of the above apply. Go to Question 6A.** | | | |

Claim #: _____

**6A**. For any job that you told us about in Question 3, did you make any of the changes below since the **DATE shown in the Identification section** (Check all that apply).

| Yes | Special Condition | Employer Name | Date (MM/DD/YYYY) | Reasons for Changes in Work Activity |
|---|---|---|---|---|
| ☐ | Stopped working | | | ☐ My physical and/or mental condition(s)<br>☐ Special conditions that allowed me to work were removed<br>☐ Other reasons (please explain in 6B) |
| ☐ | Reduced my work hours | | | ☐ My physical and/or mental condition(s)<br>☐ Special conditions that allowed me to work were removed<br>☐ Other reasons (please explain in 6B) |
| ☐ | Reduced my earnings | | | ☐ My physical and/or mental condition(s)<br>☐ Special conditions that allowed me to work were removed<br>☐ Other reasons (please explain in 6B) |
| ☐ | Changed to a lighter or easier type of work | | | ☐ My physical and/or mental condition(s)<br>☐ Special conditions that allowed me to work were removed<br>☐ Other reasons (please explain in 6B) |
| ☐ | **No,** I did not make any changes since the date shown in the Identification section. **Go to Question 7.** | | | |

**6B**. Use this space to provide any additional information about your work changes.

Claim #: _____

**7**. Do or did you spend any of your own money for items or services **related to your physical and/or mental condition(s)** that you needed in order to work and for which you did not get reimbursed? (For example; medicines or co-pays, medical devices or procedures, Braille equipment, special telephone or equipment, service animal, attendant care, modifications to a car used for work, or other special transportation.) We may ask you for proof of payment.

☐ **NO.** I did not spend any of my own money for items or services related to my physical and/or mental condition.

☐ **YES.** Please tell us what you paid below. Do not show any expenses that have been or will be paid by an insurance company, other organization, or other person.

| Describe Item or Service | Cost | Date Paid (MM/YYYY-MM/YYYY) |
|---|---|---|
| Example: *Service animal* | *$100 per day, week, month, or year* | *01/2000 - 02/2000* |
| | $_____ per_____ | |
| | $_____ per_____ | |
| | $_____ per_____ | |
| | $_____ per_____ | |

## Remarks

**Use this section to add any information you did not have space for in other parts of the form. Please show the number of the question you are answering.**

Claim #: _____

## Remarks

**Use this section to add any information you did not have space for in other parts of the form. Please show the number of the question you are answering.**

## Signature

I authorize any employer, agency, or other organization to disclose to the Social Security Administration or the State agency that may determine or review my entitlement to disability benefits, any information about my physical and/or mental condition or my work.

**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.**

| Signature of Claimant, Beneficiary or Representative | Date | Area Code and Telephone Number | |
|---|---|---|---|
| Mailing address (Number and Street, Apt. no., P.O. Box, or Rural Route) | City | State | ZIP Code |

If this statement is signed with a mark (e.g. X), two witnesses to the signing who know the person making the statement must sign below, giving their full addresses and telephone numbers.

| 1. Signature of Witness | Date | Area Code and Telephone Number | |
|---|---|---|---|
| Mailing address (Number and Street, Apt. no., P.O. Box, or Rural Route) | City | State | ZIP Code |
| 2. Signature of Witness | Date | Area Code and Telephone Number | |
| Mailing address (Number and Street, Apt. no., P.O. Box, or Rural Route) | City | State | ZIP Code |

## ~~Privacy Act Statement~~
## ~~Collection and Use of Personal Information~~

~~Sections 205(a), 1631(d)(1) and 1631(e)(1) of the Social Security Act, as amended, authorize us to collect this information. The information on this form is needed by Social Security to make a decision on the named claimant's claim. While giving us the information on this form is voluntary, failure to provide all or part of the requested information could prevent an accurate or timely decision on the named claimant's claim. We generally use the information you supply for the purpose of making decisions regarding claims.~~

~~However, we may use it for the administration and integrity of Social Security programs. We may also disclose information to another person or to another agency in accordance with approved routine uses, which include but are not limited to the following:~~

~~(1) to enable a third party or 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 the 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 of Social Security programs.~~

~~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.~~

~~A complete list of routine uses for this information is available in our System of Records Notice entitled, Earnings Record and Self-Employment Income System, 60-0059. The notice, additional information regarding this form, and information regarding our system and programs, are available on-line at www.socialsecurity.gov or at any 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 (OMB) control number. The OMB control number for this collection is 0960-0059. We estimate that it will take about 40 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.*

Claim #: _____

## ADDITIONAL EMPLOYMENT INFORMATION
## (Continuation from Page 3)

| **Employer's Name** | Supervisor's Name | Supervisor's Telephone No. (*Include area code*) |
|---|---|---|
| | | |

| Mailing address | City | State | ZIP Code |
|---|---|---|---|
| | | | |

Job Title and Type of Work

| Date Work Started (MM/DD/YYYY) | Date Work Ended (if ended) (MM/DD/YYYY) ☐ Still working | Rate of Pay $ _____ per _____ | Hours Worked per Week (on average) |
|---|---|---|---|
| | | | |

Attach copies of all your pay stubs from this employer or ask the employer for a wage print-out showing gross monthly earnings **since the DATE shown in the Identification section.**

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|---|---|---|---|---|---|
| | $ | | $ | | $ |
| | $ | | $ | | $ |
| | $ | | $ | | $ |
| | $ | | $ | | $ |

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|---|---|---|
| | | |

| Mailing address | City | State | ZIP Code |
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|---|---|---|---|---|---|
| | $ | | $ | | $ |
| | $ | | $ | | $ |
| | $ | | $ | | $ |
| | $ | | $ | | $ |

Claim #: _____

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## (Continuation from Page 3)

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|---|---|---|
| | | |

| Mailing address | City | State | ZIP Code |
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|---|---|---|---|---|---|
| | $ | | $ | | $ |
| | $ | | $ | | $ |
| | $ | | $ | | $ |
| | $ | | $ | | $ |

| **Employer's Name** | Supervisor's Name | Supervisor's Telephone No. (*Include area code*) |
|---|---|---|
| | | |

| Mailing address | City | State | ZIP Code |
|---|---|---|---|
| | | | |

Job Title and Type of Work

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|---|---|---|---|---|---|
| | $ | | $ | | $ |
| | $ | | $ | | $ |
| | $ | | $ | | $ |
| | $ | | $ | | $ |