SOCIAL SECURITY ADMINISTRATION						
Request for Reinstatement - Title XVI						
Eligible Individual	SSN					
Eligible Spouse	SSN	SSN				
my impairment is the same as (or related to) the non-medical requirements for SSI. I am no condition prevents me from performing SGA. I understand that I may be able to receive provents.	he impairment which ot performing substar	ntial gainful activity (SGA) and my medical				
is being decided.						
For persons who are entitled to any other SSA benefits based on disability or blindness:						
I understand that if SSA denies my request for reinstatement because I have medically improved, my current entitlement to SSA benefits will be reviewed and may terminate.						
I declare under penalty of perjury that I have accompanying statements or forms, and it that anyone who knowingly gives a false of information, or causes someone else to do other penalties, or both.	is true and correct r misleading staten	to the best of my knowledge. I understand nent about a material fact in this				
Signature	Date	Area Code and Telephone Number Where You Can Be Reached During the Day				
Address (Number and Street)						
City and State		ZIP Code				
WITNESSES (Write in ink)						
This request does not ordinarily have to be wit to the signing who know you must sign below		• • • • • • • • • • • • • • • • • • • •				
1. Signature of Witness	2. Signat	ture of Witness				
Address (Number and Street, City, State and Z	ZIP Code) Address	(Number and Street, City, State and ZIP Code)				

THIS INFORMATION IS ONLY NEEDED IF YOUR PROVISIONAL BENEFITS WILL BE SENT TO YOUR PRIOR REPRESENTATIVE PAYEE REPRESENTATIVE PAYEE (Write in ink)

Your Title or Relationship to the Recipient		Area Code and Reached During	•	lumber Where You Can Be
Address (Number, Street)				
City and State			ZIP Code	
Your full name (First name, middle initial, last name) Please print here	Signature	Please sign here		Date

Collection and Use of Personal Information

Section 1631(e) of the Social Security Act, as amended (42 U.S.C. § 1383(e)), authorize us to collect the information requested on this form. The information you provide will be used to make a decision on this claim. Your response is voluntary. However, failure to provide the requested information may prevent an accurate and timely decision on any claim filed, or could result in the loss of benefits.

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

- 1. To enable an agency or third party to assist Social Security in establishing rights to SSI payments;
- 2. To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level;
- 3. To comply with Federal laws requiring the disclosure of the information from our records; and,
- 4. To facilitate statistical research, audit, or investigative activities necessary to assure the integrity of SSA programs.

We may also use the information you provide when we match records by computer. Computer matching programs compare our records with those of 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.

Additional information regarding this form and our other system of records notices and Social Security programs are available from our Internet website at www.socialsecurity.gov or at your local Social Security office.

Paperwork Reduction Act - This information collection meets the requirement of 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 2 minutes to read the instructions, gather the facts, and answer the questions. SEND OR BRING 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.