SOCIAL SECURITY ADMINISTRATION/~~OFFICE OF DISABILITY ADJUDICATION AND REVIEW~~

Form Approved
OMB No.0960-0710

REQUEST TO WITHDRAW AN APPEALS COUNCIL REQUEST FOR REVIEW

Do not write in this space

IMPORTANT NOTICE – This is a request to withdraw your request for review at the Appeals Council (AC). The AC will consider this request and decide if dismissing your request for review is appropriate. If the AC denies this request, the appeals process will go on as if you had not filed this form. If the AC approves this request, the appeals process will stop. The Administrative Law Judge decision will stay in effect. The dismissal of the request for review is final and cannot be appealed.

1. CLAIMANT NAME

CLAIMANT SSN

2. WAGE EARNER NAME, IF DIFFERENT ***(or, if applicable, name of surviving eligible spouse or other individual eligible to receive benefits due a deceased claimant)***

3. CLAIMANT CLAIM NUMBER, IF DIFFERENT

4. PRINT YOUR NAME ***(First name, middle initial, last name)***

5. DATE APPEALS COUNCIL REVIEW REQUESTED

6. DATE OF ALJ DECISION

I wish to withdraw my request for review. My request is voluntary. I understand the effects of this request. Namely, the Appeals Council may dismiss my request for review. If it does, the Administrative Law Judge decision will stay in effect. This may result in the potential loss of benefits. The Appeals Council's dismissal of this request for review is final and cannot be appealed. 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.)***

SIGNATURE OF PERSON MAKING REQUEST (OPTIONAL)

☐ Continued on reverse

Signature *(First name, middle initial, last name) (Write in ink)*

Date *(Month, day, year)*

Telephone Number (Include area code)

SIGN HERE

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)

FOR USE OF SOCIAL SECURITY ADMINISTRATION

SSN:

Additional Remarks:

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 request for review 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 request for review at the Appeals Council.

We rarely use the information you supply for any purpose other than to decide if dismissing your review 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 60-0004, entitled, Working File of the Appeals Council 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.*