WAIVER	R OF RIGHT	TO APPEAR	2 - C	DISABILIT	Y HE	ARING	(DO NOT WRITE I	N THIS SPACE)	
NAME OF CL	AIMANT								
NAME OF WA	AGE EARNER O	R SELF-EMPLOYE	D	SOCIAL SEC	URITY N	IUMBER			
(CON-	ADLETE ONLY IN	I CLIDDI EMENTAL	SE.	CUDITY INC		25)			
(COMPLETE <b>ONLY</b> IN SUPPLEMENTAL SE NAME OF SPOUSE				SOCIAL SECURITY NUMBER					
TYPE		DISABILITY					SSI		
OF BENEFIT	☐ WORKER	□ WIDOW/ WIDOWER		CHILD	☐ DIS	ABILITY	BLIND	☐ CHILD	
NAME OF RE	PRESENTATIV	E, IF ANY							
REPRESENTATIVE'S ADDRESS					TELEPHONE NUMBER (INCLUDE				
AREA						AREA COI	ODE)		
opportunity the reasons could be effect opportunity the restrict my a at a hearing Although the someone reputhe evidence Administration decision in measons.	o present wither why my disabilitiective in explain o present and octivities. I have by an attorney e above has been present me at a cof record plus on. I have been ny case. In this	right to have a disa esses and explain ity benefits should ling the facts in my question witnesses been given an ex or other person of en explained to me disability hearing any evidence which advised that if I can be event, I can make	in de not y cas s and cplar f my e, I c ch I chan e the	etail to the di end. I unde se, since the d explain ho nation of my choice. do not want to refer to have may submit ge my mind, e request wit	sability I rstand the disability with my im right to read a the disability or which I can read the any So	hearing off nat this opp ty hearing pairments representa r at a disal ability hear n may be o equest a he ocial Secur	icer, who will decontunity to be seconflicer would give prevent me from tion, including rebility hearing, or bring officer decide btained by the Searing prior to the	cide my case, een and heard e me an working and presentation have e my case on ocial Security e writing of a	
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MAILING ADI	DRESS (NUMBE	R AND STREET, A	.T9.	NO., P.O. BO	X, OR RI	JRAL ROU	TE)		
CITY AND STATE					ZIP CODE				
		if this form has bee						witnesses to	
1. SIGNATURE OF WITNESS				2. SIG	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.

See Revised Privacy Act Statement Attached

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 tarely 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 <a href="https://www.socialsecurity.gov">www.socialsecurity.gov</a> 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.

## See Revised PRA Statement Attached

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.