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 at www.ssa.gov/pubs/10095.html online.

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.ssa.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 are outside the United States or its territories:
  - If you are in Canada, visit www.ssa.gov/foreign/canada.htm to find the office that services your area.
  - Contact your nearest Federal Benefits Unit (FBU). Visit www.ssa.gov/foreign/foreign.htm for a list of FBU's.
  - Write to the Social Security Administration at:
    P.O. Box 17769
    Baltimore, Maryland, 21235-7769
    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	BNC#	☐ Blind ☐ Not Blind

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 123 Any Street Your Town, MD 54321	$100.00 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 _____	

BNC#: _____

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
	$		$		$
	$		$		$
	$		$		$
	$		$		$

BNC#: _____

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.

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☐ 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 Additional Employment Information.

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): _____

Type of Payment	Employer Name	Amount or Estimate of Value	Date Received (MM/YYYY-MM/YYYY)
Example: *Sick Pay*	*ABC Company*	*$100.00 per day, week, month, or year*	*01/2000 - 02/2000*
		$ _____ per _____	
		$ _____ per _____	
		$ _____ per _____	

BNC#: _____

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.**			

BNC#: _____

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) ☐ Special conditions that allowed me to work were removed ☐ Other reasons (please explain in 6B)
☐	Reduced my work hours			☐ My physical and/or mental condition(s) ☐ Special conditions that allowed me to work were removed ☐ Other reasons (please explain in 6B)
☐	Reduced my earnings			☐ My physical and/or mental condition(s) ☐ Special conditions that allowed me to work were removed ☐ Other reasons (please explain in 6B)
☐	Changed to a lighter or easier type of work			☐ My physical and/or mental condition(s) ☐ Special conditions that allowed me to work were removed ☐ 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.

BNC#: _____

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	*$100.00 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.

BNC#: _____

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 223(d) and 1633 of the Social Security Act, as amended, allow us to collect this information. Furnishing us this information is voluntary. However, failing to provide all or part of the information may prevent an accurate and timely decision on any claim filed or could result in an overpayment of benefits.

We will use the information to make a determination of eligibility for benefits. We may also share your information for the following purposes, called routine uses:

- To employers or former employers for correcting or reconstructing earnings records and for Social Security tax purposes only; and

- To contractors and other Federal agencies, as necessary, for the purpose of assisting Social Security Administration in the efficient administration of its programs.

In addition, we may share this information in accordance with the Privacy Act and other Federal laws. For example, where authorized, we may use and disclose this information in computer matching programs, in which our records are compared with other records to establish or verify a person's eligibility for Federal benefit programs and for repayment of incorrect or delinquent debts under these programs.

A list of additional routine uses is available in our Privacy Act System of Records Notices (SORN) 60-0059, entitled Earnings Recording and Self-Employment Income System, as published in the Federal Register (FR) on January 11, 2006, at 71 FR 1819, 60-0320, entitled Electronic Disability Claim File, as published in the FR on December 22, 2003, at 68 FR 71210, and 60-0330, entitled eWork, as published in the FR on September 15, 2003, at 68 FR 54037. Additional information, and a full listing of all our SORNs, is available on our website at www.ssa.gov/privacy.

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.*

BNC#: _____

ADDITIONAL EMPLOYMENT INFORMATION
(Continuation from Page 5)

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)

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