

Complete the Request to Withdraw a Hearing Request (Form HA-85)

Instructions

This online service allows either the claimant or the appointed representative to electronically complete, sign, and submit the Request to Withdraw a Hearing Request (Form HA-85). You may use this online service as an alternative to completing a paper version of this form. To complete the form online, you will need a valid email address.

Before beginning the form, you will enter and confirm your email address in the online application.

You will receive an email from adobesign@adobesign.com containing a link and instructions to access the form. The link will expire after five (5) calendar days. If the link expires, you will need to return to this page to request a new link.

IMPORTANT: We will not process the form until you complete the form, **sign the form electronically**, and select **“Click to Sign”** to submit the form. Upon submission, you will be able to download a copy of the signed form within the application. **We recommend that you save a copy for your records.** You will receive an email confirming your submission.

If you are the claimant and have an appointed representative, you should provide a copy of the completed form you saved to your representative. If you are the appointed representative, you should provide a copy of the completed form you saved to your client.

PLEASE NOTE:

- This website is most compatible with the following browsers: Microsoft Edge and Google Chrome.
- The form must be electronically completed, signed, and submitted in a single session.
- The system will end your session after 60 minutes of inactivity and no information will be saved.
- A daily email reminder will be sent for five (5) days or until the form has been submitted.
- If you do not receive an email notification within a few minutes of your online submission, be sure to check your email's junk folder.

Sections 205(a), 1631(d)(1), and 1872 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 us from making an accurate determination regarding your request to withdraw your request for a hearing.

We will use the information you provide to decide if dismissing your hearing request is appropriate. We may also share your information for the following purposes, called routine uses:

- To a congressional office in response to an inquiry from that office made at the request of a subject of a record; and
- To a contractor or other Federal agency to assist in the efficient administration of our 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 Systems of Records Notices (SORN) 60-0005, entitled Administrative Law Judge Working File on Claimant Cases, as published in the Federal Register (FR) on April 29, 2009, at 74 FR 19617; and 60-0009, entitled Hearings and Appeals Case Control System, as published in the FR on October 13, 1982, at 47 FR 45589. Additional information, and a full listing of all our SORNs, is available on our website at www.ssa.gov/privacy.

* I understand and agree to the above statement



Request to Withdraw a Hearing Request - 85

We recommend that you verify the accuracy of your email address. If you do not receive an email notification within a few minutes of your online submission, be sure to check your email's junk folder.

Your Email Address

Confirm Your Email Address

Document Name

Completion Deadline

Submit



Social Security

Request to Withdraw a Hearing Request

To complete the online form, open the email from adobesign@adobesign.com and click on the "Review & Sign" button.



Mon 6/7/2021 2:58 PM


Social Security Administration <adobesign@adobesign.com>

[EXTERNAL] Social Security Administration Has Sent You Request to Withdraw a Hearing Request to Sign

To Claimant Email Address

Retention Policy Delete_7_Year_Default (7 years)

Expires 6/5/2028

 If there are problems with how this message is displayed, click here to view it in a web browser.



Social Security

Social Security Administration requests your signature Request to Withdraw a Hearing Request

Form Expires On June 12, 2021

[Review and sign](#)

THIS LINK EXPIRES IN FIVE (5) CALENDAR DAYS. If the link expires, please visit secure.ssa.gov/ha85-online-form to get a new link.

You have a document to review and sign. You can access the document using the link above.

The form must be electronically completed, signed, and submitted in a single session. The system will end your session after 60 minutes of inactivity and no information will be saved.

The "Review and sign" link is personalized for you and, for security purposes, we strongly recommend that you DO NOT share this email or link with others. If you DO share this email or link with others, you accept the risk that others may misuse your personal information. If you have any questions about this email or feel that you received this in error, please contact Social Security at **1-800-772-1213** (TTY **1-800-325-0778**) between 8 a.m. – 7 p.m., Monday through Friday.

Suspect Social Security Fraud?

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

SOCIAL SECURITY ADMINISTRATION

[Help us improve.](#)



By proceeding, you agree that this agreement may be signed using electronic or handwritten signatures.

To ensure that you continue receiving our emails, please add adobesign@adobesign.com to your address book or safe list.

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SOCIAL SECURITY ADMINISTRATION
OFFICE OF DISABILITY ADJUDICATION AND REVIEWForm Approved
OMB No. 0960-0710

REQUEST TO WITHDRAW A HEARING REQUEST

IMPORTANT NOTICE - This is a request to withdraw your hearing request. The judge will consider this request and decide if dismissing your hearing request is appropriate. If we deny your request, the hearing process will go on as if you had not filed this form. If we approve this request, the hearing process will stop. We will send you a dismissal notice and we will not process your case. The last determination in your case will stay in effect. If you change your mind, you must ask the judge to cancel this request to withdraw within 60 days after you get the dismissal notice. You must give a good reason why the dismissal was wrong. You may also file an appeal with the Appeals Council (AC) within 60 days after you get the dismissal notice. Even if you do not ask the judge to cancel your request, and do not file an appeal, the AC may set aside the dismissal of your hearing request. This would occur within 60 days after we mail the dismissal notice to you.

Do not write in this space

CLAIMANT NAME

CLAIMANT SSN

*

*

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

CLAIMANT CLAIM NUMBER, IF DIFFERENT

PRINT YOUR NAME (First name, middle initial, last name)

DATE OF HEARING
REQUESTBENEFIT APPLIED
FOR

TYPE OF CLAIM(S)

I wish to withdraw my hearing request. My request is voluntary. I understand the effects of this request. Namely, a judge may dismiss my hearing request. If the judge does, the last determination in my case will stay in effect, unless the dismissal is set aside. This may result in the potential loss of benefits. I understand that I have 60 days from when I get the dismissal notice to cancel my request or file an appeal with the Appeals Council. 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.)

*

 Continued on reverse

SIGNATURE OF PERSON MAKING REQUEST (OPTIONAL)

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

Date (Month, day, year)

SIGN
HERE

Click here to sign

Telephone Number (Include area code)

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)

Start

SSN: *

Additional Remarks:

Large empty yellow rectangular area for additional remarks.

FOR USE OF SOCIAL SECURITY ADMINISTRATION

- APPROVED
- NOT APPROVED BECAUSE
- CLAIMANT DOES UNDERSTAND CONSEQUENCES
- WITHDRAWAL WOULD HARM INTEREST OF CLAIMANT OR OTHER PARTIES
- OTHER (Attach explanation)

SIGNATURE OF SSA EMPLOYEE	TITLE	DATE
	<input type="checkbox"/> JUDGE	<input type="checkbox"/> OTHER (Specify)

Start

Privacy Act Statement
Collection and Use of Personal Information

Sections 205(a), 1631(d)(1), and 1872 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 us from making an accurate determination regarding your request to withdraw your request for a hearing.

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- To a contractor or other Federal agency to assist in the efficient administration of our programs.

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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.





Type



Draw



Mobile



Sign

Test Claimant

Clear

Close

Apply

SOCIAL SECURITY ADMINISTRATION
OFFICE OF DISABILITY ADJUDICATION AND REVIEWForm Approved
OMB No. 0960-0710

REQUEST TO WITHDRAW A HEARING REQUEST

IMPORTANT NOTICE - This is a request to withdraw your hearing request. The judge will consider this request and decide if dismissing your hearing request is appropriate. If we deny your request, the hearing process will go on as if you had not filed this form. If we approve this request, the hearing process will stop. We will send you a dismissal notice and we will not process your case. The last determination in your case will stay in effect. If you change your mind, you must ask the judge to cancel this request to withdraw within 60 days after you get the dismissal notice. You must give a good reason why the dismissal was wrong. You may also file an appeal with the Appeals Council (AC) within 60 days after you get the dismissal notice. Even if you do not ask the judge to cancel your request, and do not file an appeal, the AC may set aside the dismissal of your hearing request. This would occur within 60 days after we mail the dismissal notice to you.

Do not write in this space

CLAIMANT NAME

Test Claimant

CLAIMANT SSN

123456789

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

Additional Name

CLAIMANT CLAIM NUMBER, IF DIFFERENT

123123A

PRINT YOUR NAME (First name, middle initial, last name)

Test Claimant

DATE OF HEARING REQUEST

01/01/2020

BENEFIT APPLIED FOR

Test

TYPE OF CLAIM(S)

Test

I wish to withdraw my hearing request. My request is voluntary. I understand the effects of this request. Namely, a judge may dismiss my hearing request. If the judge does, the last determination in my case will stay in effect, unless the dismissal is set aside. This may result in the potential loss of benefits. I understand that I have 60 days from when I get the dismissal notice to cancel my request or file an appeal with the Appeals Council. 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.)

Test Information

 Continued on reverse

SIGNATURE OF PERSON MAKING REQUEST (OPTIONAL)

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

SIGN

Test Claimant

HERE

Test Claimant (Aug 9, 2021)

Date (Month, day, year)

08/06/2021

Telephone Number (Include area code)

1111222333

Mailing Address (Number and Street, Apt. No., PO Box, Or Rural Route)

123 Test Street

City and State

Test

ZIP Code

11111

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)

Form HA-85 (01-2014)

Page 1

SSN: 123456789



You're all set

You finished signing "Request to Withdraw a Hearing Request".

All parties will be notified via email. You can also [download a copy](#) of what you just signed.

Mon 5/17/2021 3:49 PM

Social Security Administration <adobesign@adobesign.com>

[EXTERNAL] Request to Withdraw a Hearing Request has been Signed and Filed

To Claimant Email Address

Retention Policy Delete_7_Year_Default (7 years)

Expires 5/15/2028

 If there are problems with how this message is displayed, click here to view it in a web browser.



Social Security



You're done signing
Request to Withdraw a Hearing Request

The document is complete.

For security purposes, we strongly recommend you DO NOT share this email with others. If you DO share this email, you accept the risk that others may misuse your personal information. If you have any questions about this email or feel that you received this in error, please contact Social Security at 1-800-772-1213 (TTY 1-800-325-0778) between 8 a.m. – 7 p.m., Monday through Friday.

[Help us improve.](#)



By proceeding, you agree that this agreement may be signed using electronic or handwritten signatures.

To ensure that you continue receiving our emails, please add adobesign@adobesign.com to your address book or safe list.

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