



Securing today
and tomorrow

SSA821 Online Application

Screen Package

June 25, 2021

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Application Landing Page:



Complete the Work Activity Report - Employee (Form SSA-821)

Instructions

This online service allows you to electronically complete, sign, and submit the Work Activity Report - Employee (Form SSA-821) to us. 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.

PRIOR TO USING THIS OPTION, YOU MAY HAVE RECEIVED A REQUEST TO COMPLETE A WORK ACTIVITY REPORT – EMPLOYEE (FORM SSA-821) FROM SSA.

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.

Before beginning the form, you (the person completing the online form) will enter and confirm your email address in the online application. You will also create a password that will be required for you to access the form.

You will receive an email from adobesign@adobesign.com containing a link and instructions on how to access the form.

NOTE: The form must be electronically signed and submitted within **fifteen (15) calendar days** of initiating the process online (i.e., when you enter your email address in order to receive an email with a link to the form). After fifteen (15) calendar days, the link will expire and you will have to start a new form.

After successful submission of the form, you will be able to save a copy of the completed form within the application. You will also receive an email from adobesign@adobesign.com with a link to the completed form. You will need your pre-established password to save a copy for your records.

PLEASE NOTE:

- This website is most compatible with the following browsers: Microsoft Edge and Google Chrome.
- When accessing the form, the system will end your session after 60 minutes of inactivity. Use the link in your email and your pre-established password to continue working on your form.
- Every three (3) days, an email reminder will be sent until the form has been submitted or until the time expires (i.e., fifteen (15) calendar days after initiation).
- **You will have to start a new form by returning to this website if *any* of the following situations apply:**
 - You forget or lose the password. The password **cannot** be reset.
 - You do not receive an email notification within a few minutes of your online submission. Be sure to check your junk folder.
 - You do not electronically sign and submit the form within fifteen (15) calendar days.
- You do not electronically sign and submit the form within fifteen (15) calendar days.

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

- To employers, current or former, for correcting or reconstructing earnings records and for Social Security tax purposes; 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 June 4, 2020, at 85 FR 34477; 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.

*** I understand and agree to the above statement**

Email and Password Landing Page:



Work Activity Report - Employee

We recommend that you verify the accuracy of your email address and make note of your password prior to submission.

You will have to start a new form by returning to this website if any of the following situations apply:

- You forget or lose the password. The password cannot be reset.
- You do not receive an email notification within a few minutes of your online submission. Be sure to check your junk folder.
- You do not electronically sign and submit the form within fifteen (15) calendar days.

Claimant Email

Confirm Claimant Email

Document Name

Password Required

Password must contain at least 8 characters, 1 uppercase, 1 lowercase, and 1 number.

Show Password

Completion Deadline

Submit

On this page, the claimant sets the password that will be used to access the form.

Email Confirmation Page:





Work Activity Report - Employee

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


First Email:

Mon 6/7/2021 3:06 PM


 Social Security Administration <adobesign@adobesign.com>
[EXTERNAL] Social Security Administration Has Sent You Work Activity Report - Employee to Sign

To  Claimant Email

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.

Action Items

 **Social Security**

Social Security Administration requests your signature
Work Activity Report - Employee

Form Expires On June 22, 2021

[Review and sign](#)

THIS LINK EXPIRES IN FIFTEEN (15) CALENDAR DAYS.

You have a document to review and sign. You can access the document using the link above. For additional security, you were required to set a password in order to review the document.

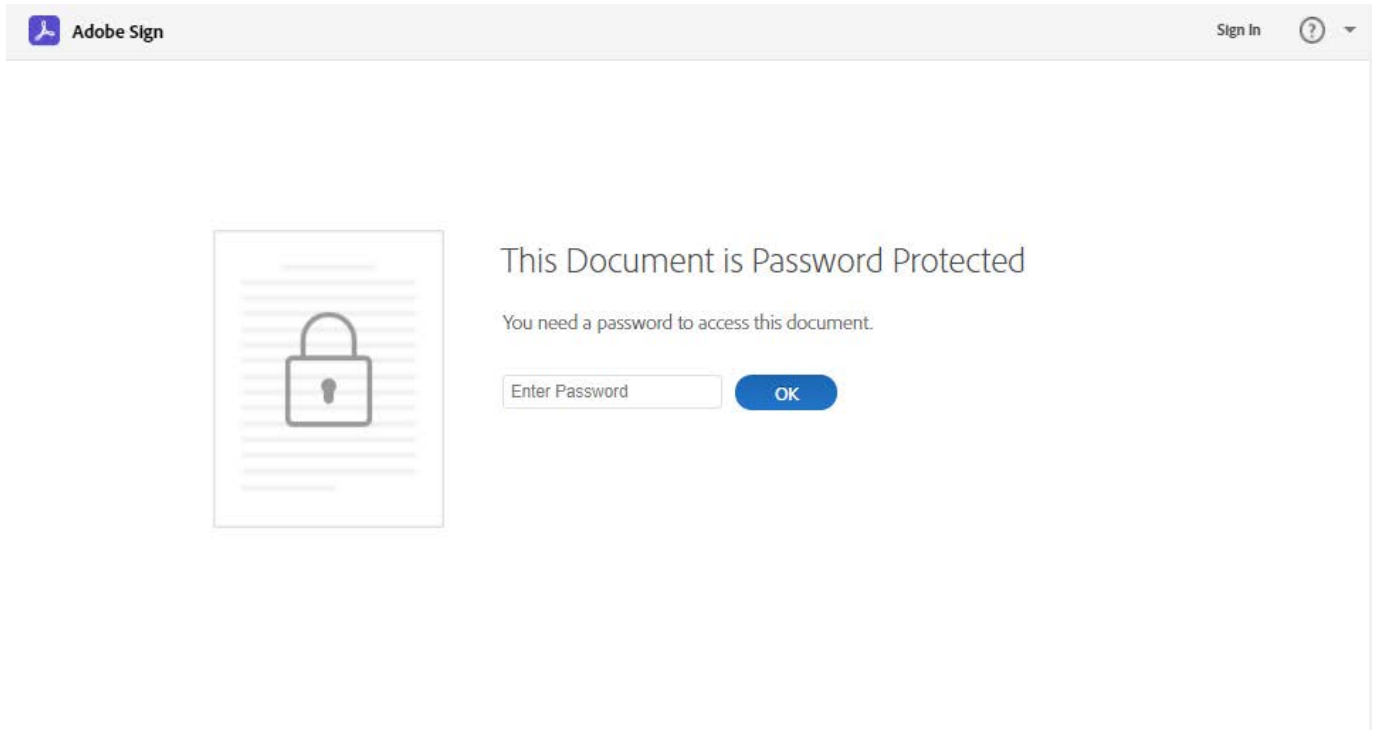
You will have to start a new form if you forget or lose your password, or if you do not electronically sign and submit the form within fifteen (15) calendar days. The password cannot be reset. To start a new form, please visit <https://secure.ssa.gov/ssa821-online-form>.

The "Review and sign" link is personalized for you and, for security purposes, we recommend that you do NOT forward/share this email or link with others. If you DO forward/share this email or link with others, you accept the risk that, by sharing your personal information, the person assisting you may misuse your personal information. If you have any questions about this email or feel that you received this in error, please contact SSA at 1-800-772-1213 (TTY 1-800-325-0778) between 8:00 am – 7:00 pm, Monday through Friday.

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 1-800-501-2101).

SOCIAL SECURITY ADMINISTRATION

Password Confirmation:



The screenshot shows the Adobe Sign interface. At the top left is the Adobe Sign logo. At the top right are the words "Sign In" and a help icon (a question mark in a circle) with a dropdown arrow. The main content area features a document icon with a padlock, indicating password protection. To the right of the icon, the text reads "This Document is Password Protected" followed by "You need a password to access this document." Below this text is a text input field labeled "Enter Password" and a blue "OK" button.

The claimant must provide the password to access the form.

Adobe Sign

Work Activity Report - Employee (...)

Form SSA-821-BK (02-2021) UF
Discontinue Prior Editions

Page 1 of -11
OMB No. 0960-0059

Social Security Administration Retirement, Survivors, and Disability Insurance Important Information

We believe you may have recent work activity and we need to know more about it. If you are applying for disability benefits, the information you provide will help us decide if you can receive benefits. If you are currently receiving disability benefits, the information you provide helps us decide if you can continue to receive benefits.

What You Need To Do

Please complete, electronically sign, and submit the form **within 15 calendar days**. It is important to fill out the form carefully and completely. If you do not submit this form, we will make our determination based on the evidence we have in our records.

Some Information To Help You Complete This Form

Our records may show self-employment income we have for you. To see your yearly earnings in our records, please [sign in to your my Social Security account or create one here](#). Our records may not show your work for this year or last year. You may have additional information in your tax returns or business records. You should add any additional work information as you complete the form.

For More Information

Please read the 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 available at <https://www.ssa.gov/pubs/EN-05-10095.pdf>.

Suspect Social Security Fraud?

If you suspect Social Security fraud, please visit <https://oig.ssa.gov> 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 find your local office using our [Social Security Office Locator](#).
- 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 <https://www.ssa.gov/foreign/canada.htm> to find the office that services your area.
 - Contact the nearest Federal Benefits Unit (FBU). Visit <https://www.ssa.gov/foreign/foreign.htm> for a list of FBUs.
 - Write to the Social Security Administration at:
P.O. Box 17769
Baltimore, Maryland 21235-7769
USA

Please have this form with you if you contact us. If you write, please include a copy of this form. It will help us answer your questions.

Start

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SSA821 Adobe Form:

Adobe Sign

Work Activity Report - Employee (...)

Form SSA-821-BK (02-2021) UF
Discontinue Prior Editions
Social Security Administration

Page 2 of 11
OMB No. 0960-0059

Work Activity Report - Employee Identification

Name of Claimant or Beneficiary * SSN# * 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.

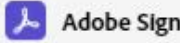
2. If you did not work, other types of income may have been reported for you. Please complete the information below. We may ask you for proof of this income. When you are finished, go to Question 7.

Type of Payment	Name and Address of Payer	Amount	Date Worked (MM/YYYY-MM/YYYY)
<input checked="" type="checkbox"/> Example	ABC Company 123 Any Street Your Town, MD 54321	\$100.00 per day, week, month, or year	01/2000 - 02/2000
<input type="checkbox"/> Back Pay		\$ USD per	-
<input type="checkbox"/> Vacation Pay		\$ USD per	-
<input type="checkbox"/> Holiday Pay		\$ USD per	-
<input type="checkbox"/> Bonus or Commission		\$ USD per	-
<input type="checkbox"/> Royalties		\$ USD per	-
<input type="checkbox"/> Sick Pay		\$ USD per	-
<input type="checkbox"/> Disability Pay		\$ USD per	-
<input type="checkbox"/> Insurance Payment		\$ USD per	-
<input type="checkbox"/> Workers Comp		\$ USD per	-
<input type="checkbox"/> Other (Please explain)		\$ USD per	-

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Red asterisks notate a required field. Note that some required fields are conditional, based upon how the prior question was answered. Please see page 20 for an example.

SSA821 Adobe Form:


Work Activity Report - Employee (...)
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Form SSA-821-BK (02-2021) UF
Page 3 of 11

SSN#: *

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) <input type="checkbox"/> Still working	Rate of Pay \$ * USD 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
	\$ USD		\$ USD		\$ USD
	\$ USD		\$ USD		\$ USD
	\$ USD		\$ USD		\$ USD
	\$ USD		\$ USD		\$ USD

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) <input type="checkbox"/> Still working	Rate of Pay \$ * USD 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
	\$ USD		\$ USD		\$ USD
	\$ USD		\$ USD		\$ USD
	\$ USD		\$ USD		\$ USD
	\$ USD		\$ USD		\$ USD

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Work Activity Report - Employee (...)

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Form SSA-821-BK (02-2021) UF
Page 4 of 11

SSN#: *

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) <input type="checkbox"/> Still working	Rate of Pay \$ * USD 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
	\$ USD		\$ USD		\$ USD
	\$ USD		\$ USD		\$ USD
	\$ USD		\$ USD		\$ USD
	\$ USD		\$ USD		\$ USD

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
		\$ USD per	-
		\$ USD per	-
		\$ USD per	-

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SSA821 Adobe Form:

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Work Activity Report - Employee (...)

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SSN#: * [REDACTED]

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
<input type="checkbox"/>	Had extra help, extra supervision or a job coach		-	
<input type="checkbox"/>	Worked irregular or fewer hours than other workers		-	
<input type="checkbox"/>	Given special equipment because of my condition		-	
<input type="checkbox"/>	Took more rest periods than other workers		-	
<input type="checkbox"/>	Given special transportation to and from work		-	
<input type="checkbox"/>	Had fewer or easier duties than other workers		-	
<input type="checkbox"/>	Allowed to produce less work than other workers		-	
<input type="checkbox"/>	Hired through special training or therapy program		-	
<input type="checkbox"/>	Given work that was suited to my condition		-	
<input type="checkbox"/>	Given special help getting ready for work		-	
<input type="checkbox"/>	Other (explain)		-	
<input type="checkbox"/>	Other (explain)		-	
<input type="checkbox"/>	None of the above apply. Go to Question 6A.			

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Work Activity Report - Employee (...)
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Form SSA-821-BK (02-2021) UF
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SSN#: *

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

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Adobe Sign

Work Activity Report - Employee (...)

Form SSA-821-BK (02-2021) UF Page 7 of 11

SSN: *

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)
<i>Example: Service animal</i>	<i>\$100.00 per day, week, month, or year</i>	<i>01/2000 - 02/2000</i>
	\$ USD per	-
	\$ USD per	-
	\$ USD per	-
	\$ USD 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.

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SSN: ★

Additional Attachments

You may attach documentation such as pay stubs or wage print outs from the employers you listed in section 3 on this form. You should also provide proof of any payments for items or services related to your physical and/or mental condition(s) shown in section 7, and/or any other employment-related documents you feel are pertinent to this work activity report. If we need additional documentation, we will contact you.

[Click to Attach File 1](#)

[Click to Attach File 2](#)

[Click to Attach File 3](#)

[Click to Attach File 4](#)

[Click to Attach File 5](#)

[Click to Attach File 6](#)

[Click to Attach File 7](#)

[Click to Attach File 8](#)

[Click to Attach File 9](#)

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	
★ Click here to sign		★ <input type="text"/>	★ <input type="text"/>	
★ <input type="text"/>		★ <input type="text"/>	★ <input type="text"/>	★ <input type="text"/>

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		
<input type="text"/>		<input type="text"/>	<input type="text"/>		
Mailing Address (Number and Street, Apt. no., P.O. Box, or Rural Route)		City		State	ZIP Code
<input type="text"/>		<input type="text"/>		<input type="text"/>	<input type="text"/>
2. Signature of Witness		Date	Area Code and Telephone Number		
<input type="text"/>		<input type="text"/>	<input type="text"/>		
Mailing Address (Number and Street, Apt. no., P.O. Box, or Rural Route)		City		State	ZIP Code
<input type="text"/>		<input type="text"/>		<input type="text"/>	<input type="text"/>

The screenshot shows an Adobe Sign interface. At the top left is the Adobe Sign logo. The document title is "Work Activity Report - Employee (...)". The document is identified as "Form SSA-821-BK (02-2021) UF" and is "Page 9 of 11". A yellow "Start" button is on the left. The main content is a "Privacy Act Statement" titled "Collection and Use of Personal Information". It explains that information collection is voluntary but necessary for benefits. It lists routine uses: correcting earnings records and assisting Social Security Administration. It also mentions sharing information for computer matching programs. A link to "www.ssa.gov/privacy" is provided. Below this is a "Paperwork Reduction Act Statement" stating the collection meets requirements of 44 U.S.C. § 3507 and estimates a 40-minute completion time.

Adobe Sign

Work Activity Report - Employee (...)

Form SSA-821-BK (02-2021) UF Page 9 of 11

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

- To employers, current or former, for correcting or reconstructing earnings records and for Social Security tax purposes; 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 June 4, 2020, at 85 FR 34477; 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.

Navigation icons: up, down, 9 / 11, zoom in, zoom out, download, close.


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Work Activity Report - Employee (...)
B

Form SSA-821-BK (02-2021) UF
Page 10 of 11

SSN#: *

ADDITIONAL EMPLOYMENT INFORMATION
 (Continuation from Page 5)

Employer's Name	Supervisor's Name	Supervisor's Telephone No. <i>(include area code)</i>	
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) <input type="checkbox"/> Still working	Rate of Pay \$ * USD 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
	\$ USD		\$ USD		\$ USD
	\$ USD		\$ USD		\$ USD
	\$ USD		\$ USD		\$ USD
	\$ USD		\$ USD		\$ USD

Employer's Name	Supervisor's Name	Supervisor's Telephone No. <i>(include area code)</i>	
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) <input type="checkbox"/> Still working	Rate of Pay \$ * USD 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
	\$ USD		\$ USD		\$ USD
	\$ USD		\$ USD		\$ USD
	\$ USD		\$ USD		\$ USD
	\$ USD		\$ USD		\$ USD

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Adobe Sign
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Work Activity Report - Employee (...)
13

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SSN#: *

ADDITIONAL EMPLOYMENT INFORMATION
(Continuation from Page 5)

Employer's Name	Supervisor's Name	Supervisor's Telephone No. <i>(include area code)</i>
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) <input type="checkbox"/> Still working	Rate of Pay \$ * USD 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
	\$ USD		\$ USD		\$ USD
	\$ USD		\$ USD		\$ USD
	\$ USD		\$ USD		\$ USD
	\$ USD		\$ USD		\$ USD

Employer's Name	Supervisor's Name	Supervisor's Telephone No. <i>(include area code)</i>
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) <input type="checkbox"/> Still working	Rate of Pay \$ * USD 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
	\$ USD		\$ USD		\$ USD
	\$ USD		\$ USD		\$ USD
	\$ USD		\$ USD		\$ USD
	\$ USD		\$ USD		\$ USD

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Adding Attachments:

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. [Click to Attach Employer 1](#)

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
	\$ USD		\$ USD		\$ USD

Still working

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
	\$ USD		\$ USD		\$ USD

Users have the ability to add attachments to the document as they see fit. Once the file is uploaded the user will see the file name appear in the box where the attachment field was.

Example of Conditional Requirements:

SSN#: *

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 Test		Supervisor's Name Test		Supervisor's Telephone No. (include area code)	
Mailing Address 123 Test		City Test	State ...	ZIP Code 12345	
Job Title and Type of Work Test					
Date Work Started (MM/DD/YYYY) 01/01/2021	Date Work Ended (if ended) (MM/DD/YYYY) 05/01/2021	<input type="checkbox"/> Still working	Rate of Pay \$ \$15.00 per ...	Hours Worked per Week (on average) 10	

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. FILE: Test File.docx x

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
	\$ USD		\$ USD		\$ USD
	\$ USD		\$ USD		\$ USD
	\$ USD		\$ USD		\$ USD
	\$ USD		\$ USD		\$ USD

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)	<input type="checkbox"/> Still working	Rate of Pay \$ *USD 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
	\$ USD		\$ USD		\$ USD
	\$ USD		\$ USD		\$ USD
	\$ USD		\$ USD		\$ USD
	\$ USD		\$ USD		\$ USD

Form SSA-821-BK (02-2021) UF Page 3 of 11

SSN#: *

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 Test		Supervisor's Name Test		Supervisor's Telephone No. (include area code)	
Mailing Address 123 Test		City Test	State ...	ZIP Code 12345	
Job Title and Type of Work Test					
Date Work Started (MM/DD/YYYY) 01/01/2021	Date Work Ended (if ended) (MM/DD/YYYY) 05/01/2021	<input type="checkbox"/> Still working	Rate of Pay \$ \$15.00 per ...	Hours Worked per Week (on average) 10	

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. FILE: Test File.docx x

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
	\$ USD		\$ USD		\$ USD
	\$ USD		\$ USD		\$ USD
	\$ USD		\$ USD		\$ USD
	\$ USD		\$ USD		\$ USD

3B. If you do not have any more employers, go to Question 4.

Previous Employer's Name Test Test		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)	<input type="checkbox"/> Still working	Rate of Pay \$ *USD 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
	\$ USD		\$ USD		\$ USD
	\$ USD		\$ USD		\$ USD
	\$ USD		\$ USD		\$ USD
	\$ USD		\$ USD		\$ USD

The SSA-821's questions are based on conditional values. The example displayed above shows that by entering an employer in question 3B, the remaining fields for 3B are yellow allowing the user to enter information. Even though the fields for question 3B appear with an asterisk in the image to the left, they are not required until a value is entered in the conditional field "Previous Employer's Name."

Signature:

The screenshot shows the Adobe Sign interface. At the top, there's a toolbar with 'Type', 'Draw', and 'Mobile' options. A modal window is open, featuring a red arrow pointing down with the Adobe logo and the word 'Sign'. Below the arrow is a vertical line for a signature. At the bottom of the modal are 'Close' and 'Apply' buttons. The background shows a form with a 'Signature' section. A yellow arrow labeled 'Next' points to the 'Click here to sign' field. The form includes fields for 'Date', 'Area Code and Telephone Number', 'Mailing Address', 'City', 'State', and 'ZIP Code'. Below the signature field, there are two witness sections, each with fields for 'Signature of Witness', 'Date', 'Area Code and Telephone Number', 'Mailing Address', 'City', 'State', and 'ZIP Code'.

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	
* Click here to sign	* Self	*	*	*
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

By clicking in the Signature field the user can type their name to sign the document.

Signature Completion:

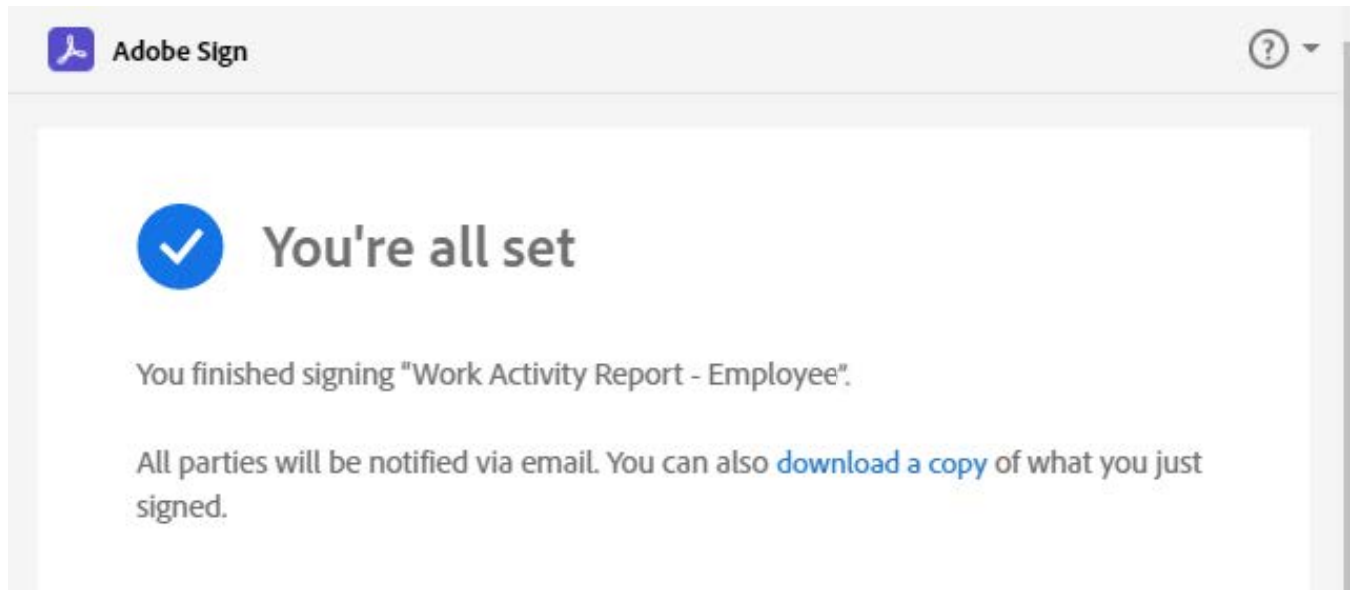
Signature			
I authorize any employer, agency, or other organization to disclose to the Social Security Administration or the State agency that may determine or review my entitlement to disability benefits, any information about my physical and/or mental condition or my work.			
I declare under penalty 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 <u>Test Test</u>		Self	Date 06/11/2021
Mailing Address (Number and Street, Apt. no., P.O. Box, or Rural Route) Test St		City Baltimore	Area Code and Telephone Number 1234567890
		State ...	ZIP Code 12345
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

*By signing, I agree to both this agreement and the [Consumer Disclosure](#).
My use of Adobe Sign is governed by the [Adobe Terms of Use](#).*

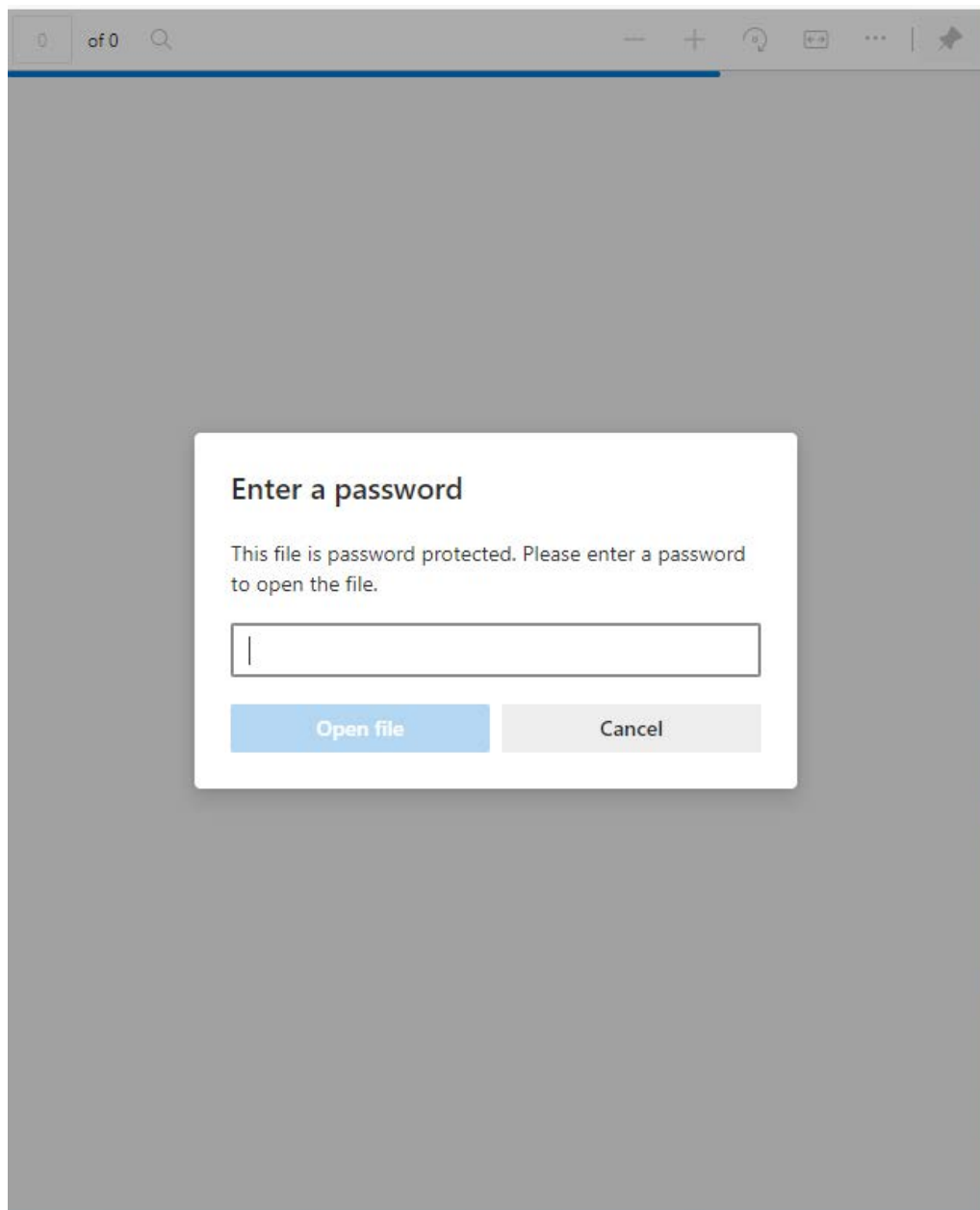
[Click to Sign](#)

Signature now appears on the form with the date it was signed appearing below signature. If all required fields are completed, user can "Click to Sign".

SSA821 Adobe Form Completion Page:




Password Request Page:




After clicking the link on the form completion page, the user will be prompted to enter the pre-established password to view the completed form.


Final Email:


Tue 6/8/2021 9:09 AM


 Social Security Administration <adobesign@adobesign.com>
[EXTERNAL] Work Activity Report - Employee has been Signed and Filed

To  Claimant Email

Retention Policy Delete_7_Year_Default (7 years) Expires 6/6/2028

 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
Work Activity Report - Employee

[Open Document](#)


The document is complete.

You can [open the final document](#) to review its activity history or download a copy for reference.

For additional security, you set a password for this document. You will need the password to review this document. If you forget or lose the password, it cannot be reset.

This link is personalized for you and, for security purposes, we recommend you do NOT forward/share this email or link with others. If you DO forward/share this email or link with others, you accept the risk that, by sharing your personal information, the person assisting you may misuse your personal information. If you have any questions about this email or feel that you received this in error, please contact SSA at 1-800-772-1213 (TTY 1-800-325-0778) between 8:00 am - 7:00 pm, Monday through Friday.

The document is fully executed. The Social Security Administration has control over the retention period for this document, which determines the amount of time it will be available for download from Adobe Sign. Adobe recommends that you save a local copy of this fully-executed document for your records.

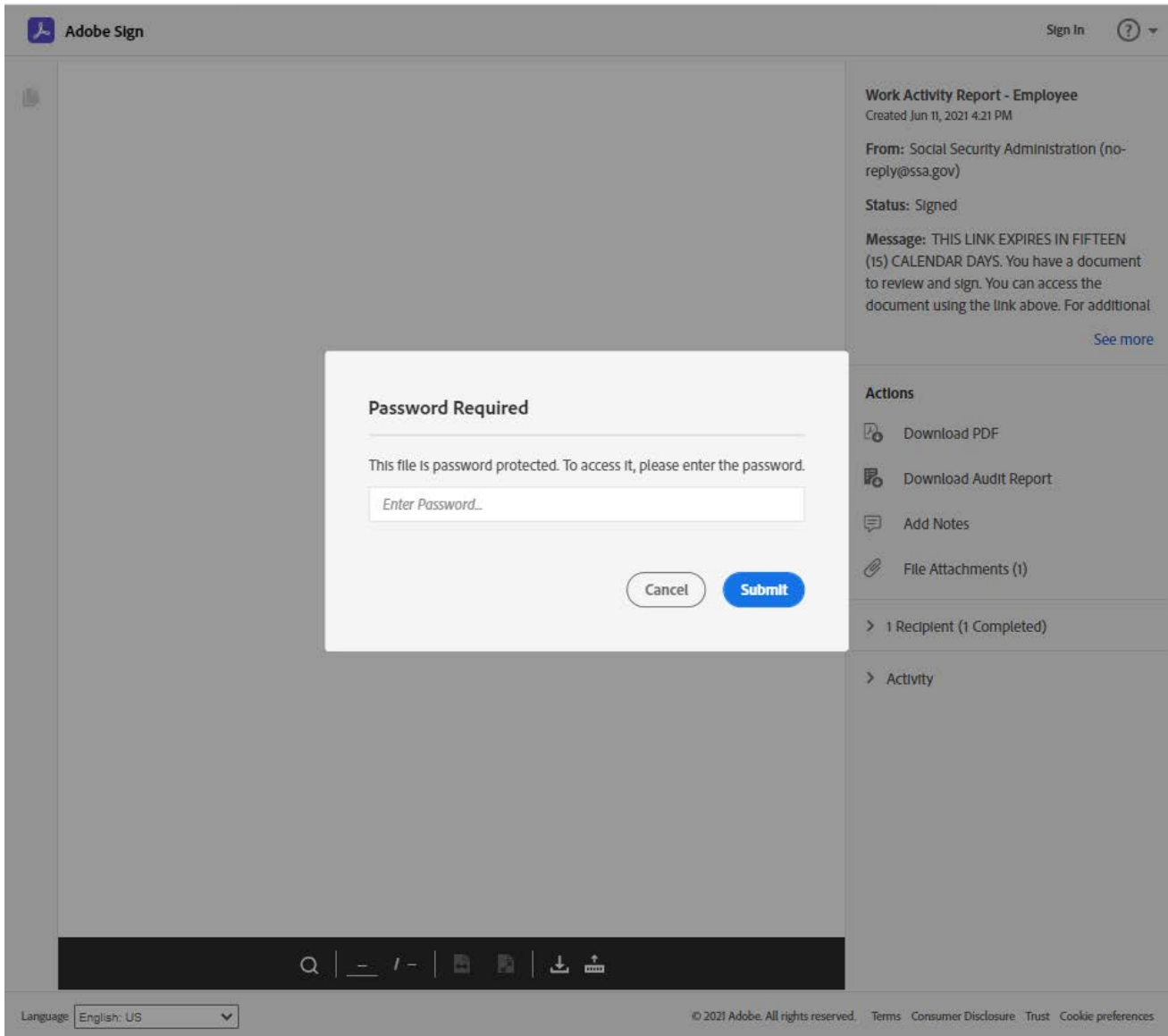
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Password Request Page:



After clicking the link in the final email, the user will be prompted to enter the pre-established password to view the completed form.

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Form **SSA-821-BK** (02-2021) UF Page 1 of -11
Discontinue Prior Editions OMB No. 0960-0059

Social Security Administration Retirement, Survivors, and Disability Insurance Important Information

We believe you may have recent work activity and we need to know more about it. If you are applying for disability benefits, the information you provide will help us decide if you can receive benefits. If you are currently receiving disability benefits, the information you provide helps us decide if you can continue to receive benefits.

What You Need To Do

Please complete, electronically sign, and submit the form **within 15 calendar days**. It is important to fill out the form carefully and completely. If you do not submit this form, we will make our determination based on the evidence we have in our records.

Some Information To Help You Complete This Form

Our records may show self-employment income we have for you. To see your yearly earnings in our records, please [sign in to your my Social Security account or create one here](#). Our records may not show your work for this year or last year. You may have additional information in your tax returns or business records. You should add any additional work information as you complete the form.

For More Information

Please read the 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 available at <https://www.ssa.gov/pubs/EN-05-10095.pdf>.

Suspect Social Security Fraud?

If you suspect Social Security fraud, please visit <https://oig.ssa.gov> 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 find your local office using our [Social Security Office Locator](#).
- 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 <https://www.ssa.gov/foreign/canada.htm> to find the office that services your area.
 - Contact the nearest Federal Benefits Unit (FBU). Visit <https://www.ssa.gov/foreign/foreign.htm> for a list of FBUs.
 - Write to the Social Security Administration at:
P.O. Box 17769
Baltimore, Maryland 21235-7769
USA

Please have this form with you if you contact us. If you write, please include a copy of this form. It will help us answer your questions.

Work Activity Report - Employee
Created Jun 11, 2021 4:21 PM

From: Social Security Administration (no-reply@ssa.gov)

Status: Signed

Message: THIS LINK EXPIRES IN FIFTEEN (15) CALENDAR DAYS. You have a document to review and sign. You can access the document using the link above. For additional [See more](#)

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> Activity

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Form SSA-821-BK (02-2021) UF
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Social Security Administration

Page 2 of 11
OMB No. 0960-0059

Work Activity Report - Employee Identification

Name of Claimant or Beneficiary Test Test	SSN# 123456789	<input type="checkbox"/> Blind <input checked="" type="checkbox"/> 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 01/01/2021

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)
<input checked="" type="checkbox"/> Example	ABC Company 123 Any Street Your Town, MD 54321	\$100.00 per day, week, month, or year	01/2000 - 02/2000
<input type="checkbox"/> Back Pay		\$ per	-
<input type="checkbox"/> Vacation Pay		\$ per	-
<input type="checkbox"/> Holiday Pay		\$ per	-
<input type="checkbox"/> Bonus or Commission		\$ per	-
<input type="checkbox"/> Royalties		\$ per	-
<input type="checkbox"/> Sick Pay		\$ per	-
<input type="checkbox"/> Disability Pay		\$ per	-
<input type="checkbox"/> Insurance Payment		\$ per	-
<input type="checkbox"/> Workers Comp		\$ per	-

Work Activity Report - Employee

Created Jun 11, 2021 4:21 PM

From: Social Security Administration (no-reply@ssa.gov)

Status: Signed

Message: THIS LINK EXPIRES IN FIFTEEN (15) CALENDAR DAYS. You have a document to review and sign. You can access the document using the link above. For additional

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Actions

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> 1 Recipient (1 Completed)

> Activity

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Form SSA-821-BK (02-2021) UF
Page 3 of 11

SSN#: 123456789

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 Test		Supervisor's Name Test	Supervisor's Telephone No. <i>(include area code)</i>	
Mailing Address 123 Test		City Test	State MD	ZIP Code 12345
Job Title and Type of Work Test				
Date Work Started (MM/DD/YYYY) 01/01/2021	Date Work Ended (if ended) <input type="checkbox"/> Still working (MM/DD/YYYY) 05/01/2021	Rate of Pay \$ 15.00 per Hour		Hours Worked per Week (on average) 10

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. Employer 1

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 Test Test		Supervisor's Name	Supervisor's Telephone No. <i>(include area code)</i>	
Mailing Address 123 HGN St		City Test	State MD	ZIP Code 12345
Job Title and Type of Work Test				
Date Work Started (MM/DD/YYYY) 01/01/2020	Date Work Ended (if ended) <input type="checkbox"/> Still working (MM/DD/YYYY) 12/20/2020	Rate of Pay \$ 10.00 per Hour		Hours Worked per Week (on average) 10.

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
	\$		\$		\$
	\$		\$		\$
	\$		\$		\$
	\$		\$		\$

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Work Activity Report - Employee
Created Jun 11, 2021 4:21 PM

From: Social Security Administration (no-reply@ssa.gov)

Status: Signed

Message: THIS LINK EXPIRES IN FIFTEEN (15) CALENDAR DAYS. You have a document to review and sign. You can access the document using the link above. For additional security, you were required to set a password

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➤ Activity

The green paperclip indicates that the user uploaded a document to that field.

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Form SSA-821-BK (02-2021) UF
Page 4 of 11

SSN#: 123456789

3C. If you do not have any more employers, go to Question 4.

Previous Employer's Name	Supervisor's Name	Supervisor's Telephone No. <small>(include area code)</small>	
Mailing Address	City	State	ZIP Code
Job Title and Type of Work			
Date Work Started <small>(MM/DD/YYYY)</small>	Date Work Ended (if ended) <small>(MM/DD/YYYY)</small>	<input type="checkbox"/> 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 <small>MM/YYYY</small>	Amount	Date Earned <small>MM/YYYY</small>	Amount	Date Earned <small>MM/YYYY</small>	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 <small>(MM/YYYY-MM/YYYY)</small>
Example: Sick Pay	ABC Company	\$100.00 per day, week, month, or year	01/2000 - 02/2000
		\$ _____ per _____	
		\$ _____ per _____	
		\$ _____ per _____	

Language: English: US
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Work Activity Report - Employee

Created Jun 11, 2021 4:21 PM

From: Social Security Administration (no-reply@ssa.gov)

Status: Signed

Message: THIS LINK EXPIRES IN FIFTEEN (15) CALENDAR DAYS. You have a document to review and sign. You can access the document using the link above. For additional security, you were required to set a password

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> Activity

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Form SSA-821-BK (02-2021) UF
Page 5 of 11

SSN#: 123456789

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
<input type="checkbox"/>	Had extra help, extra supervision or a job coach		-	
<input type="checkbox"/>	Worked irregular or fewer hours than other workers		-	
<input type="checkbox"/>	Given special equipment because of my condition		-	
<input type="checkbox"/>	Took more rest periods than other workers		-	
<input type="checkbox"/>	Given special transportation to and from work		-	
<input type="checkbox"/>	Had fewer or easier duties than other workers		-	
<input type="checkbox"/>	Allowed to produce less work than other workers		-	
<input type="checkbox"/>	Hired through special training or therapy program		-	
<input type="checkbox"/>	Given work that was suited to my condition		-	
<input type="checkbox"/>	Given special help getting ready for work		-	
<input type="checkbox"/>	Other (explain)		-	
<input type="checkbox"/>	Other (explain)		-	
<input type="checkbox"/>	None of the above apply. Go to Question 6A.			

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

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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.

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Additional Attachments

Use this section to add any attachments you did not have space for in other parts of the form. Please indicate the number of the question you are answering in the file name.

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 <i>Test Test</i> <small>Test Test Jun 11, 2021 10:50 EDT</small>	Self	Date 06/11/2021	Area Code and Telephone Number 1234567890
Mailing Address (Number and Street, Apt. no., P.O. Box, or Rural Route) Test St	City Baltimore	State MD	ZIP Code 12345

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

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

- To employers, current or former, for correcting or reconstructing earnings records and for Social Security tax purposes; 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 June 4, 2020, at 85 FR 34477; 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.

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ADDITIONAL EMPLOYMENT INFORMATION
 (Continuation from Page 5)

Employer's Name	Supervisor's Name	Supervisor's Telephone No. <small>(include area code)</small>
Mailing Address	City	State ZIP Code
Job Title and Type of Work		
Date Work Started <small>(MM/DD/YYYY)</small>	Date Work Ended (if ended) <input type="checkbox"/> Still working <small>(MM/DD/YYYY)</small>	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
	\$		\$		\$
	\$		\$		\$
	\$		\$		\$
	\$		\$		\$

Employer's Name	Supervisor's Name	Supervisor's Telephone No. <small>(include area code)</small>
Mailing Address	City	State ZIP Code
Job Title and Type of Work		
Date Work Started <small>(MM/DD/YYYY)</small>	Date Work Ended (if ended) <input type="checkbox"/> Still working <small>(MM/DD/YYYY)</small>	Rate of Pay \$ _____ per
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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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	\$		\$		\$
	\$		\$		\$
	\$		\$		\$

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

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	\$		\$		\$
	\$		\$		\$
	\$		\$		\$

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