Print Claimant Copy

Social Security Administration

Form Approved
OMB No. 0960-0351

NOTICE REGARDING SUBSTITUTION OF PARTY UPON DEATH OF CLAIMANT RECONSIDERATION OF DISABILITY CESSATION

NAME OF DECEASED CLAIMANT	CLAIM FOR

Print DHU Copy

WAGE EARNER'S NAME (LEAVE BLANK IF SAME AS ABOVE)	SOCIAL SECURITY NUMBER

I have been informed that the claimant had requested reconsideration of a disability cessation but died before action on the request was completed. I understand that the deceased claimant's request for reconsideration of disability cessation may not be processed unless an eligible person is substituted. My relationship to the deceased claimant:

☐ WIDOW/WIDOWER ☐ SURVIVING DIVORCED SPOUSE

Print Claims File Copy

If you have checked either of the above boxes and have in your care the deceased's child (children) who is (are) under age 18 (or an eligible student) or disabled, check here ☐

☐ CHILD ☐ DISABLED CHILD ☐ PARENT ☐ ADMINISTRATOR/ EXECUTOR OF ESTATE ☐ OTHER (DESCRIBE) _____

Print Other Copy

COMPLETE EITHER 1 OR 2

☐ 1. I wish to be made a substitute party and to proceed with the reconsideration of a disability cessation requested by the deceased.

CHECK EITHER a, b, OR c.

If the Social Security Administration decides that a hearing is necessary:

☐ a. I want to come to the disability hearing in person as already scheduled

☐ b. I want to come to a hearing in person but request a later time or different location (specify number of days, location desired)

☐ c. I do not want to come to a hearing in person, and I request a decision on the evidence of record.

☐ 2. I do not wish to proceed with the reconsideration of a disability cessation requested by the deceased, and I hereby request withdrawal of the deceased's request for reconsideration of a disability cessation. I have had a full explanation of the effects of a withdrawal.

SIGNATURE (FIRST NAME, MIDDLE INITIAL, LAST NAME)	DATE (MONTH, DAY, YEAR)
	TELEPHONE NUMBER (INCLUDE AREA CODE)

PRINT OR TYPE FULL NAME

MAILING ADDRESS (NUMBER AND STREET ADDRESS, P.O. BOX OR RURAL ROUTE)

CITY, STATE	ZIP CODE

Witnesses are required only if this form has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the person requesting reconsideration must sign below, giving their full addresses.

1. SIGNATURE OF WITNESS	2. SIGNATURE OF WITNESS
ADDRESS (NUMBER AND STREET, CITY, STATE, ZIP CODE)	ADDRESS (NUMBER AND STREET, CITY, STATE, ZIP CODE)

Privacy Act Statement
Collection and Use of Personal Information

See Revised Privacy Act & PRA Statements attached

Section 205(b) of the Social Security Act, as amended, authorizes us to collect this information. We will use the information you provide to determine entitlement to your claim. Furnishing us this information is voluntary. However, failing to provide us with all or part of the information may prevent an accurate and timely decision on any claim filed, or could result in loss of benefits. We rarely use the information you supply us for any purpose other than to determine continued eligibility of Social Security benefits. We may also disclose information to another person or to another agency in accordance with approved routine uses, which include but are not limited to the following:

1. To enable a third party or an agency to assist us in establishing rights to Social Security benefits and/or coverage;

2. To comply with Federal laws requiring the release of information from Social Security records (e.g., to the Government Accountability Office and Department of Veterans' Affairs);

3. To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level; and,

4. To facilitate statistical research, audit, or investigative activities necessary to assure the integrity and improvement of Social Security programs (e.g., to the Bureau of the Census).

We may also use the information you give us in computer matching programs. Matching programs compare our records with records kept by other Federal, State, or local government agencies. Information from these matching programs can be used to establish or verify a person's eligibility for federally-funded or administered benefit programs and for repayment of payments or delinquent debts under these programs.

A complete list of routine uses of the information you provided us is available in our Systems of Records Notices entitled, Claim Folders System, 60-0089 and Electronic Disability (eDIB)Claim File, 60-0320. These notices, additional information regarding this form, and information regarding our programs and systems, are available on-line at www.socialsecurity.gov or at your local Social Security office.

PAPERWORK REDUCTION ACT : This information collection meets the clearance requirements of 44 U.S.C. §3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You are not required to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take you about 5 minutes to read the instructions, gather the necessary facts, and answer the questions.

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NOTICE REGARDING SUBSTITUTION OF PARTY UPON DEATH OF CLAIMANT RECONSIDERATION OF DISABILITY CESSATION

NAME OF DECEASED CLAIMANT	CLAIM FOR

WAGE EARNER'S NAME (LEAVE BLANK IF SAME AS ABOVE)	SOCIAL SECURITY NUMBER

I have been informed that the claimant had requested reconsideration of a disability cessation but died before action on the request was completed. I understand that the deceased claimant's request for reconsideration of disability cessation may not be processed unless an eligible person is substituted. My relationship to the deceased claimant:

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☐ CHILD ☐ DISABLED CHILD ☐ PARENT ☐ ADMINISTRATOR/ EXECUTOR OF ESTATE ☐ OTHER (DESCRIBE) _____

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☐ 2. I do not wish to proceed with the reconsideration of a disability cessation requested by the deceased, and I hereby request withdrawal of the deceased's request for reconsideration of a disability cessation. I have had a full explanation of the effects of a withdrawal.

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	TELEPHONE NUMBER (INCLUDE AREA CODE)

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I have been informed that the claimant had requested reconsideration of a disability cessation but died before action on the request was completed. I understand that the deceased claimant's request for reconsideration of disability cessation may not be processed unless an eligible person is substituted. My relationship to the deceased claimant:

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