

Request for Reinstatement - Title XVI

Eligible Individual	BNC#
Eligible Spouse	BNC#

I request reinstatement of my Supplemental Security Income (SSI) Disability benefits. I am blind or disabled and my impairment is the same as (or related to) the impairment which was the basis for my prior eligibility. I meet the non-medical requirements for SSI. I am not performing substantial gainful activity (SGA) and my medical condition prevents me from performing SGA.

I understand that I may be able to receive provisional (temporary) payments while my request for reinstatement is being decided.

For persons who are entitled to any other SSA benefits based on disability or blindness:

I understand that if SSA denies my request for reinstatement because I have medically improved, my current entitlement to SSA benefits will be reviewed and may terminate.

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	Date	Area Code and Telephone Number Where You Can Be Reached During the Day
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Address (Name and Street Number)	
City and State	ZIP Code

WITNESSES (Write in ink)

This request does not ordinarily have to be witnessed. If, however, you have signed by mark (x), two witnesses to the signing who know you must sign below giving their full addresses.

1. Signature of Witness	2. Signature of Witness
Address (Number and Street, City, State, and ZIP Code)	Address (Number and Street, City, State, and ZIP Code)

**THIS INFORMATION IS ONLY NEEDED IF YOUR PROVISIONAL BENEFITS WILL BE SENT TO YOUR
PRIOR REPRESENTATIVE PAYEE
REPRESENTATIVE PAYEE (Write in ink)**

Your Title or Relationship to the Recipient		Area Code and Telephone Number Where You Can Be Reached During the Day	
Address (Number, Street)			
City and State		ZIP Code	
Your full name (First name, middle initial, last name) Please print here	Signature Please sign here		Date

**Privacy Act Statement
Collection and Use of Personal Information**

Section 223 of the Social Security Act, as amended, authorizes 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 and timely decision on benefit eligibility.

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

- To Federal, State or local agencies (or agents on their behalf) for administering cash or non-cash income maintenance or health maintenance programs (including programs under the Act); and
- Disclosure to contractors and other Federal agencies, as necessary, for the purpose of assisting the Social Security Administration in the efficient administration of its programs.

In addition, we may share this information in accordance with the Privacy Act or 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) 60-0089, entitled Claims Folder System, as published in the Federal Register (FR) on April 1, 2003, at 68 FR 15784; 60-0103, entitled Supplemental Security Income Record and Special Veterans Benefits, as published in the FR on January 1, 2006, at 71 FR 1830; and, 60-0320, entitled Electronic Disability (eDIB) Claim File, as published in the FR on December 22, 2003, at 68 FR 71210. Additional information, and a full listing of all of 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 control number. We estimate that it will take about 2 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. The office is listed under U. S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213 (TTY 1-800-325-0778).** You may send comments on our time estimate above to: SSA, 6401 Security Blvd, Baltimore, MD 21235-6401. **Send only comments relating to our time estimate to this address, not the completed form.**