

# Social Security Administration

## Retirement, Survivors, and Disability Insurance

### Important Information

Date: \_\_\_\_\_

BNC#: \_\_\_\_\_

We are writing to you because we believe you may have recent work activity and we need to know more about this work activity. Please tell us about your work since \_\_\_\_\_. 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 and return the form **within 15 days** to the address shown above. It is important to fill out the form carefully and completely. You may also submit this form online at <https://www.ssa.gov/forms/ssa-820.html>. Remember to sign and date the form. If you do not return 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 show the following self-employment income for you. This list may not be complete. It may not show your work for this year or last year. You should add any additional work information as you complete the form.

Income Reported for You		
Self-Employment	Year	Yearly Income

**For More Information**

Please read the enclosed pamphlet: Working While Disabled: How We Can Help. It will tell you more about why we need to know about your work, and will explain our rules about working. This pamphlet is also available at [www.ssa.gov/pubs/EN-05-10095.pdf](http://www.ssa.gov/pubs/EN-05-10095.pdf) online.

**Suspect Social Security Fraud?**

If you suspect Social Security fraud, please visit <http://oig.ssa.gov/report> or call the Inspector General's Fraud Hotline at **1-800-269-0271** (TTY **1-866-501-2101**).

**Need more help?**

1. Visit [www.ssa.gov](http://www.ssa.gov) for fast, simple, and secure online service.
2. Call us at 1-800-772-1213, weekdays from 8:00 am to 7:00 pm. If you are deaf or hard of hearing, call TTY 1-800-325-0778. Please mention this letter when you call.
3. You may also call your local office at \_\_\_\_\_ .

How are we doing? Go to [www.ssa.gov/feedback](http://www.ssa.gov/feedback) to tell us.

**Social Security Administration**

Enclosures:

SSA Pub No. 05-10095

Pre-addressed Envelope

## Work Activity Report - Self-Employment

### Identification - To Be Completed by SSA

Name of Claimant or Beneficiary	BNC#	<input type="checkbox"/> Blind <input type="checkbox"/> Not Blind
Please use this form to describe your work activity since <b>(Insert alleged onset date, date of entitlement, or last determination date, as appropriate)</b>		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 self-employment income **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.** For a list of the income that was reported for you, please refer to page 1 in the section entitled **Income Reported for You.**
- YES. Go to Question 3.**

2. If you did not work, but income was reported for you, for each row on page 1 under the section **Income Reported for You**, please provide additional information about the income. If the income reported for you is an error, please explain in the **Remarks** section of the form. When you are finished go to the **Signature** section to complete the form.

Self-Employment Description	Name and Address of Payer	Payment or estimate of value	Date Worked (MM/YYYY-MM/YYYY)
Example: Income after business stopped	ABC Company 123 Any Street Your Town, MD 54321	\$100 per day, week, month, or year	01/2000 - 02/2000
		\$ _____ per _____	
		\$ _____ per _____	

3. Please tell us about your work **since the DATE shown in the Identification section.**

Type of Self-Employment or Name of Business	Area Code and Telephone Number	Area Code and Fax Number
Mailing address	City	State ZIP

What is the primary product or service?

Date Work Started (MM/DD/YYYY)	Date Work Ended (if ended) (MM/DD/YYYY)	Still Working <input type="checkbox"/>	Average Number of Hours Worked per Month
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Type of ownership arrangement? (Check one)

- Sole Owner     
  Limited Liability Company (LLC)     
  Independent Contractor  
 Corporation     
  Partnership     
  Other (Please explain)  
 Farm Landlord     
  Farm Tenant

BNC#: \_\_\_\_\_

4. In the space below, show each month you worked in your business, the net earnings, and if you worked 45 hours or more.

Date Worked MM/YYYY	Net Earnings	Worked more than 45 hours per month?		Date Worked MM/YYYY	Net Earnings	Worked more than 45 hours per month?	
		<input type="checkbox"/> Yes	<input type="checkbox"/> No			<input type="checkbox"/> Yes	<input type="checkbox"/> No
		<input type="checkbox"/> Yes	<input type="checkbox"/> No			<input type="checkbox"/> Yes	<input type="checkbox"/> No
		<input type="checkbox"/> Yes	<input type="checkbox"/> No			<input type="checkbox"/> Yes	<input type="checkbox"/> No
		<input type="checkbox"/> Yes	<input type="checkbox"/> No			<input type="checkbox"/> Yes	<input type="checkbox"/> No
		<input type="checkbox"/> Yes	<input type="checkbox"/> No			<input type="checkbox"/> Yes	<input type="checkbox"/> No
		<input type="checkbox"/> Yes	<input type="checkbox"/> No			<input type="checkbox"/> Yes	<input type="checkbox"/> No
		<input type="checkbox"/> Yes	<input type="checkbox"/> No			<input type="checkbox"/> Yes	<input type="checkbox"/> No
		<input type="checkbox"/> Yes	<input type="checkbox"/> No			<input type="checkbox"/> Yes	<input type="checkbox"/> No
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		<input type="checkbox"/> Yes	<input type="checkbox"/> No			<input type="checkbox"/> Yes	<input type="checkbox"/> No
		<input type="checkbox"/> Yes	<input type="checkbox"/> No			<input type="checkbox"/> Yes	<input type="checkbox"/> No
		<input type="checkbox"/> Yes	<input type="checkbox"/> No			<input type="checkbox"/> Yes	<input type="checkbox"/> No

If you need more room for your answers, go to the Remarks section.

5. Please attach all of your self-employment tax returns (including Schedule C & SE or 1099) since the DATE shown in the Identification section.

- I have **ENCLOSED** my Tax Returns. Go to Question 6.
- I **DO NOT have Tax Returns**. For any years that you DO NOT have tax returns, use the chart below to tell us about your total annual gross and net self-employment income.

Year (YYYY)	Gross	Net	Year (YYYY)	Gross	Net
	\$	\$		\$	\$
	\$	\$		\$	\$

6. Has anyone besides yourself had **management responsibilities** for this business (i.e., a partner, employee, relative, or helper) since the DATE shown in the Identification section?

- NO. Go to Question 7.**
- YES.** Complete the questions below.
  - How many hours per month (on average) does or did the other person(s) spend on management duties? \_\_\_\_\_ Hours per month
  - How many hours per month (on average) do or did you spend on management duties? \_\_\_\_\_ Hours per month
- Please tell us what duties you and the other person performed below.

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BNC#: \_\_\_\_\_

### Remarks

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

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### 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(s) or my work.

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly gives a false or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime and may be sent to prison, or may face other penalties, or both.

Signature of Claimant, Beneficiary or Representative		Date	Area Code and Telephone Number	
Mailing address		City	State	ZIP

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		City	State	ZIP

2. Signature of Witness		Date	Area Code and Telephone Number	
Mailing address		City	State	ZIP

## Privacy Act Statement Collection and Use of Personal Information

See revised Privacy Act Statement

~~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.~~

~~We will use the information you provide to determine benefits eligibility. We may also share the information for the following purposes, called routine uses:~~

- ~~• To officers and employees of Federal, State or local agencies upon written request, in accordance with the Internal Revenue Code (IRC) (U.S.C. 6103(l)(7)), tax return information (e.g., information with respect to net earnings from self-employment, wages, payments of retirement income which have been disclosed to the Social Security Administration, and business and employment addresses) for purposes of, and to the extent necessary in, determining an individual's eligibility for, or the correct amount of, benefits under certain programs listed in the IRC; and~~
- ~~• To employers, current or former, for correcting or reconstructing earnings records and for Social Security tax purposes.~~

~~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 Notice (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, and 60-0089, Claims Folders System, as published in the FR on October 31, 2019, at 84 FR 58422. Additional information, and a full listing of all of our SORNs, is available on our website at [www.ssa.gov/privacy](http://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. We estimate that it will take about 30 minutes to read the instructions, gather the facts, and answer the questions. **Send only comments regarding this burden estimate or any other aspect of this collection, including suggestions for reducing this burden to: SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.**