



Securing today
and tomorrow

SSA820 Online Application

Screen Package

August 9, 2021



Complete the Work Activity Report - Self-Employment (Form SSA-820)

Instructions

This online service allows you to electronically complete, sign, and submit the Work Activity Report – Self-Employment (Form SSA-820). 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 – SELF-EMPLOYMENT (FORM SSA-820) FROM SOCIAL SECURITY.

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 on how to access the form. The link will expire after fifteen (15) 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.

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.
- An email reminder will be sent every three (3) days for fifteen (15) 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 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.

* I understand and agree to the above statement

Email Landing Page:



Work Activity Report - Self Employment - 820

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

Confirm Your Email

Document Name

Completion Deadline

Submit

Email Confirmation Page:




Work Activity Report - Self Employment

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 2:58 PM
Social Security Administration <adobesign@adobesign.com>
[EXTERNAL] Social Security Administration Has Sent You Work Activity Report - Self Employment 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 - Self Employment**

Form Expires On June 22, 2021

[Review and sign](#)

THIS LINK EXPIRES IN FIFTEEN (15) CALENDAR DAYS. If the link expires, please visit secure.ssa.gov/ssa820-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.](#)

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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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SSA820 Cover Sheet:

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OMB No. 0980-0598

**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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Work Activity Report - Self Em...
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Social Security Administration

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OMB No. 0960-0598

Work Activity Report - Self-Employment

Identification

Name of Claimant or Beneficiary *	SSN# *	<input type="radio"/> Blind
		<input type="radio"/> 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 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, 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
		\$ USD per	-
		\$ USD 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

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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 16 for an example.

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Work Activity Report - Self Em...
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SSN#: *

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?	
	USD	Yes	No		USD	Yes	No
	USD	<input type="checkbox"/> Yes	<input type="checkbox"/> No		USD	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	USD	<input type="checkbox"/> Yes	<input type="checkbox"/> No		USD	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	USD	<input type="checkbox"/> Yes	<input type="checkbox"/> No		USD	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	USD	<input type="checkbox"/> Yes	<input type="checkbox"/> No		USD	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	USD	<input type="checkbox"/> Yes	<input type="checkbox"/> No		USD	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	USD	<input type="checkbox"/> Yes	<input type="checkbox"/> No		USD	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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	USD	<input type="checkbox"/> Yes	<input type="checkbox"/> No		USD	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	USD	<input type="checkbox"/> Yes	<input type="checkbox"/> No		USD	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	USD	<input type="checkbox"/> Yes	<input type="checkbox"/> No		USD	<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
	\$ USD	\$ USD		\$ USD	\$ USD
	\$ USD	\$ USD		\$ USD	\$ USD

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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Start

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SSN# *

7. Since the DATE shown in the Identification section did you make any changes in your work activity due to your physical and/or mental condition(s)?

NO. Go to Question 8.

YES. Please describe your changes below (Check all that apply below).

Type of change	Date (MM/DD/YYYY)	Please Explain
<input type="checkbox"/> Stopped Working		
<input type="checkbox"/> Reduced my work hours		My hours reduced from _____ per _____ to _____ per _____ because _____
<input type="checkbox"/> Changed to lighter or easier work		
<input type="checkbox"/> Other changes		

8. Has any person or organization contributed to or paid for any business expenses or provided any free help, items, or services related to your business since the DATE shown in the Identification section (For example: rent, supplies, inventory, purchase, repair of equipment, or an employee or helper that works for you for free)?

NO. Go to Question 9.

YES. Describe the expenses paid or items or services provided, their value of the contribution, and who provided them below.

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SSN# *

9. 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 by any other individual or party? (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. Go to the next section.

* YES. 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: Money spent for medicines	\$100 per day, week, month, or year	01/2009 - 02/2009
	\$ 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: *

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.

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 * Click here to sign	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

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Next

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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.

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.

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.*

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Attachment Fields:

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Work Activity Report - Self Employ...

Form SSA-820-BK (XX-2021) UF Page 3 of 7 SSN# *

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?
USD	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	USD	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
USD	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	USD	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
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USD	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	USD	<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. [Click to A...](#) [Click to A...](#)

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

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.

Form SSA-820-BK (XX-2021) UF Page 5 of 7 SSN# *

9. 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 by any other individual or party? (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. Go to the next section.

YES. 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. [Click to A...](#) [Click to A...](#)

Describe Item or Service	Cost	Date Paid (MM/YYYY-MM/YYYY)
Example: Money spent for medicines	\$100 per day, week, month, or year	01/2009 - 02/2009
	\$ 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.

Example of Conditional Required Fields:

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 Social Security Administration

Work Activity Report - Self-Employment

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 determine whether you are eligible for receiving disability benefits.

If you have had self-employment income since the DATE shown above in the Identification section? (check one)

YES. Go to Question 3.

NO. If you did not work, but income was reported for you, please refer to page 1 in the section entitled Income Reported for You.

2. If you did not work, but income was 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
		\$ USD per	-
		\$ USD 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 Average Number of Hours Worked per Month *

Type of ownership arrangement? (Check one)

Sole Owner Limited Liability Company (LLC) Independent Contractor

Corporation Partnership Other (Please explain)

Farm Landlord Farm Tenant

Next

Saved

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The SSA820's questions are based on conditional values. The example displayed above shows that by selecting "YES" to question 1, question 2 is not available to enter information in, and the user can move onto question 3.

Signature:

The screenshot displays the Adobe Sign interface. At the top, the Adobe Sign logo is visible on the left, and a help icon is on the right. Below the logo, there are icons for 'Type', 'Draw', and 'Mobile' with their respective labels. A 'Next Required' indicator shows '25' items. A large red arrow with the Adobe logo and the word 'Sign' points downwards. Below this, a white modal box contains a vertical line and two buttons: 'Close' and 'Apply'. The background shows a document form with the following sections:

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
* Click here to sign * Self * 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

At the bottom of the screen, there is a 'Saved' status, navigation arrows, a page indicator '6 / 7', and zoom controls.

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

Completed Signature:

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 <u>Test Test</u> <small>Test Test (06/10/2021)</small> Self	Date 06/10/2021	Area Code and Telephone Number 1234567890	
Mailing address 123 ABC Lane	City Test	State MD	ZIP 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	City	State	ZIP
2. Signature of Witness	Date	Area Code and Telephone Number	
Mailing address	City	State	ZIP


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 filled out, user can "Click to Sign".



Adobe Sign




 **You're all set**


You finished signing "Work Activity Report - Self Employment".

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


Final Email:


Tue 6/8/2020 10:47 AM


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

To  Claimant Email

Retention Policy Delete_7_Year_Default (7 years) Expires 6/8/2028

 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 – Self Employment

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.

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