OMB No. 0960-0349

REQUEST FOR RECONSIDERATION - DISABILITY CESSATION RIGHT TO APPEAR (SEE REVERSE SIDE FOR PAPERWORK/PRIVACY ACT NOTICE)		FOR SOCIAL SECURITY OFFICE USE ONLY **(DO NOT WRITE IN THIS SPACE)**
NAME OF CLAIMANT	SOCIAL SECURITY NUMBER	☐ FO Code ______
NAME OF WAGE EARNER OR SELF-EMPLOYED PERSON (if different from Claimant)	SOCIAL SECURITY NUMBER	☐ Benefit Continuation
SPOUSE'S NAME AND SOCIAL SECURITY NUMBER (COMPLETE ONLY IN SUPPLEMENTAL SECURITY INCOME CASE)		☐ Foreign Language Notice ______

TYPE OF BENEFIT	**DISABILITY**			**SSI**		
	☐ WORKER	☐ WIDOW	☐ CHILD	☐ DISABILITY	☐ BLIND	☐ CHILD

I DO NOT AGREE WITH THE DETERMINATION TO STOP DISABILITY BENEFITS AND I REQUEST RECONSIDERATION.

My reasons are (reasons should relate to the basis for stopping disability benefits and be as specific as possible):

NOTE: If the notice of the determination on your claim is dated more than 65 days ago, include your reason for not making this request earlier. Include the date on which you received the notice.

I AM SUBMITTING THE FOLLOWING ADDITIONAL INFORMATION (If "NONE" write "NONE")
(Attach additional page if needed):

We are adding the following language to the box:

I understand that I do not need to provide additional information or evidence to submit this form. I will be able to provide additional evidence until the date of the hearing. It is preferable that I provide additional information or evidence at the earliest possible time.

CHECK BLOCK 1 AND THE STATEMENTS THAT APPLY <u>OR</u> CHECK BLOCK 2

☐ 1. **<u>I (and/or my representative) wish to appear</u>** at a disability hearing. The disability hearing will be with a person called a disability hearing officer and it will let me explain why I do not agree with the decision to stop benefits.

☐ I need an interpreter at the disability hearing - Language ______________________
(If you need an interpreter, SSA will prov

We are revising the language to:
I do not wish to appear nor do I wish a representative to appear for me at the disability hearing and I request that a decision be made based on the evidence in my case (Complete SSA-773 Waiver of Right to Appear - Disability Hearing)

OR

☐ 2. **<u>I do not wish to appear nor do I wish a repre</u>** lity ~~hearing. I have been advised of my right to have a disability hearing.~~ ~~give me a chance to present witnesses. It will also let me explain to the disab~~ ~~efits should not end. I understand that this chance to be seen and hea~~ ~~learn about the facts in my case. The disability hearing officer would give n~~ ~~out my condition give information and explain how my condition keep~~ ~~ies. I have been told about my right to representation at the disability hearing,~~ ~~other person of my choice. Although the above has been explained to me, I do not want to appear at a disability hearing, or have someone represent me at a disability hearing. I prefer to have the disability hearing officer decide my case on the evidence in my file, plus any evidence that I submit or that may be obtained by the Social Security Administration. I have been advised that if I change my mind, I can request a disability hearing prior to the writing of a decision in my case. In this case, I can make the request with any Social Security office.~~

Anyone who knowingly makes or causes to be made a false statement or representation of material fact for use in determining a payment under the Social Security Act, or knowingly conceals or fails to disclose an event with an intent to affect an initial or continued right to payment, or submits or causes to be submitted any false statement or document knowing the same to contain any misrepresentation of material fact, commits a crime punishable under Federal law by fine, imprisonment, or both, and may be subject to administrative sanctions.

ENTER ADDRESSES FOR BOTH THE CLAIMANT AND REPRESENTATIVE (IF REPRESENTED)

NAME OF CLAIMANT			NAME OF CLAIMANT'S REPRESENTATIVE		
STREET ADDRESS			REPRESENTATIVE'S ADDRESS		
CITY	STATE	ZIP CODE	CITY	STATE	ZIP CODE
TELEPHONE NUMBER	DATE		TELEPHONE NUMBER	DATE	

Privacy Act Statement
Collection and Use of Personal Information

We are revising the Privacy Act Statement

~~Section 205(b) of the Social Security Act, as amended, allows us to collect this information. Furnishing u[illegible] 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 loss of benefits.~~

~~We will use the information you provide to determine a substitute party and pursue an appeal on behalf of a deceased claimant. We may also share your information for the following purposes, called routine uses:~~

~~• To student volunteers, individuals working under a personal services contract, and other workers who technically do not have the status of Federal employees, when they are performing work for us, as authorized by law, and they need access to personally identifiable information (PII) in our records in order to perform their assigned agency functions; and~~

~~• To contractors and other Federal Agencies, as necessary, for the purpose of assisting us in the efficient administration of our programs. We will disclose information under this routine use only in situations in which we may enter into a contractual or similar agreement with a third party to assist in accomplishing an SSA function relating to this system of records.~~

~~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 (SORNs) 60-0089, entitled Claims Folders System, as published in the Federal Register (FR) on October 31, 2019, at 84 FR 58422; and 60-0320, Electronic Disability (eDIB) Claim File, as published in the FR on June 4, 2020, at 85 FR 34477 Additional information, and a full listing of all our SORNs is, available on our website at www.ssa.gov/privacy.~~

Paperwork Reduction Act Statement

We are revising the 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 5 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