

# Social Security Administration

## Retirement, Survivors, and Disability Insurance

### Important Information

FO Address

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 completed form **within 15 days** to the address shown above. It is important to fill out the form carefully and completely. Remember to sign and date the form. If you do not return this form, we may contact your employer or make our determination based on the evidence we have in our records.

#### Some Information To Help You Complete This Form

Our records show these employers and yearly earnings 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.

Employer Name	Year	Earnings

## 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 <https://www.ssa.gov/pubs/EN-05-10095.pdf> online.

## Suspect Social Security Fraud?

If you suspect Social Security fraud, please visit <https://oig.ssa.gov/report> 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](http://www.ssa.gov) to find general information about Social Security.
- Call us toll-free at **1-800-772-1213**, or call your local office at \_\_\_\_\_. You may also call your Social Security contact, \_\_\_\_\_ at \_\_\_\_\_. We can answer most questions over the phone.
- Write or visit any Social Security office. If you plan to visit an office, you may call ahead to make an appointment. The office that serves your area is located at:
  - 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 [www.ssa.gov/foreign/canada.htm](http://www.ssa.gov/foreign/canada.htm) to find the office that services your area.
    - Contact your nearest Federal Benefits Unit (FBU). Visit [www.ssa.gov/foreign/foreign.htm](http://www.ssa.gov/foreign/foreign.htm) for a list of FBU's.
    - Write to the Social Security Administration at:  
P.O. Box 17769  
Baltimore, Maryland, 21235-7769  
USA

Please have this letter with you if you call or visit an office. If you write, please include a copy of this letter. It will help us answer your questions.

**Social Security Administration**

Enclosures:  
SSA Pub No. 05-10095  
Pre-addressed Envelope

## Work Activity Report - Employee Identification - To Be Completed by SSA

Name of Claimant or Beneficiary	BNC#	<input type="checkbox"/> Blind <input type="checkbox"/> Not Blind
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Please use this form to describe your work activity since (Insert alleged onset date, date of entitlement, or last determination date, as appropriate)	Date
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### 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 employment income or wages 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.**
- YES. Go to Question 3.**

2. If you did not work, other types of income may have been reported for you. Please complete the information below. We may ask you for proof of this income. When you are finished, go to Question 7.

Type of Payment	Name and Address of Payer	Amount	Date Worked (MM/YYYY-MM/YYYY)
<input checked="" type="checkbox"/> Example	ABC Company 123 Any Street Your Town, MD 54321	\$100.00 per day, week, month, or year	01/2000 - 02/2000
<input type="checkbox"/> Back Pay		\$ _____ per _____	
<input type="checkbox"/> Vacation Pay		\$ _____ per _____	
<input type="checkbox"/> Holiday Pay		\$ _____ per _____	
<input type="checkbox"/> Bonus or Commission		\$ _____ per _____	
<input type="checkbox"/> Royalties		\$ _____ per _____	
<input type="checkbox"/> Sick Pay		\$ _____ per _____	
<input type="checkbox"/> Disability Pay		\$ _____ per _____	
<input type="checkbox"/> Insurance Payment		\$ _____ per _____	
<input type="checkbox"/> Workers Comp		\$ _____ per _____	
<input type="checkbox"/> Other (Please explain)		\$ _____ per _____	

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

**3A.** Please tell us about your work **since the DATE shown in the Identification section, beginning with your most recent employer.** If you are not sure about this, ask your employer(s) to help you. Use the additional space provided in the Remarks section if you need more room for your answer.

<b>Current or Most Recent Employer's Name</b>	Supervisor's Name	Supervisor's Telephone No. <i>(include area code)</i>	
Mailing Address	City	State	ZIP Code

Job Title and Type of Work

Date Work Started (MM/DD/YYYY)	Date Work Ended (if ended) (MM/DD/YYYY) <input type="checkbox"/> Still working	Rate of Pay \$ _____ per _____	Hours Worked per Week (on average)
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Attach copies of all your pay stubs from this employer or ask the employer for a wage print-out showing gross monthly earnings **since the DATE** shown in the Identification section.

- I have **ENCLOSED Pay Stubs or Gross Wage Print Outs.**
- I **DO NOT have Pay Stubs or Gross Wage Print Outs.** For any months that you DO NOT have pay stubs or a print-out, use the chart below to tell us how much you earned (before deductions) in each month.

Date Earned MM/YYYY	Amount	Date Earned MM/YYYY	Amount	Date Earned MM/YYYY	Amount
	\$		\$		\$
	\$		\$		\$
	\$		\$		\$
	\$		\$		\$

**3B.** If you do not have any more employers, **go to Question 4.**

<b>Previous Employer's Name</b>	Supervisor's Name	Supervisor's Telephone No. <i>(include area code)</i>	
Mailing Address	City	State	ZIP Code

Job Title and Type of Work

Date Work Started (MM/DD/YYYY)	Date Work Ended (if ended) (MM/DD/YYYY) <input type="checkbox"/> Still working	Rate of Pay \$ _____ per _____	Hours Worked per Week (on average)
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Attach copies of all your pay stubs from this employer or ask the employer for a wage print-out showing gross monthly earnings **since the DATE** shown in the Identification section.

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	\$		\$		\$
	\$		\$		\$
	\$		\$		\$

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

**3C.** If you do not have any more employers, **go to Question 4.**

<b>Previous Employer's Name</b>		Supervisor's Name		Supervisor's Telephone No. <i>(include area code)</i>	
Mailing Address			City	State	ZIP Code
Job Title and Type of Work					
Date Work Started (MM/DD/YYYY)	Date Work Ended (if ended) <input type="checkbox"/> Still working (MM/DD/YYYY)	Rate of Pay \$ _____ per _____		Hours Worked per Week (on average)	

Attach copies of all your pay stubs from this employer or ask the employer for a wage print-out showing gross monthly earnings **since the DATE** shown in the Identification section.

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	\$		\$		\$
	\$		\$		\$
	\$		\$		\$

If you have more employers, go to Additional Employment Information.

**4.** Do or did you get any other payment(s) or benefit(s) from an employer **in addition to the regular pay** shown in Question 3?

**NO. Go to Question 5.**

**YES. Please check all that apply below.**

- |  |   |                                       |                                |                                       |
|--|---|---------------------------------------|--------------------------------|---------------------------------------|
| <input type="checkbox"/> Sick Pay                      | <input type="checkbox"/> Disability Pay | <input type="checkbox"/> Vacation Pay | <input type="checkbox"/> Tips  | <input type="checkbox"/> Bonus        |
| <input type="checkbox"/> Transportation                | <input type="checkbox"/> Car or Vehicle | <input type="checkbox"/> Childcare    | <input type="checkbox"/> Meals | <input type="checkbox"/> Room or Rent |
| <input type="checkbox"/> Other (Please explain): _____ |   |                                       |                                |                                       |

Type of Payment	Employer Name	Amount or Estimate of Value	Date Received (MM/YYYY-MM/YYYY)
Example: Sick Pay	ABC Company	\$100.00 per day, week, month, or year	01/2000 - 02/2000
		\$ _____ per _____	
		\$ _____ per _____	
		\$ _____ per _____	

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

## 5. For any job(s) that you told us about in Question 3, have you worked under any special conditions listed below?

Yes	Special Condition	Employer Name	Date (MM/YYYY to MM/YYYY)	Please Describe
<input type="checkbox"/>	Had extra help, extra supervision or a job coach			
<input type="checkbox"/>	Worked irregular or fewer hours than other workers			
<input type="checkbox"/>	Given special equipment because of my condition			
<input type="checkbox"/>	Took more rest periods than other workers			
<input type="checkbox"/>	Given special transportation to and from work			
<input type="checkbox"/>	Had fewer or easier duties than other workers			
<input type="checkbox"/>	Allowed to produce less work than other workers			
<input type="checkbox"/>	Hired through special training or therapy program			
<input type="checkbox"/>	Given work that was suited to my condition			
<input type="checkbox"/>	Given special help getting ready for work			
<input type="checkbox"/>	Other (explain)			
<input type="checkbox"/>	Other (explain)			
<input type="checkbox"/>	None of the above apply. <b>Go to Question 6A.</b>			









## Privacy Act Statement Collection and Use of Personal Information

Sections 223(d) and 1633 of the Social Security Act allows 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 or could result in an overpayment of benefits.

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

- To employers, current or former, for correcting or reconstructing earnings records and for Social Security tax purposes; and
- To private medical and vocational consultants, for use in preparing for, or evaluating the results of, consultative medical examinations or vocational assessments which they were engaged to perform by SSA or a State agency, in accordance with sections 221 or 1633 of the Social Security Act.

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 (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 60-0320, entitled 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](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 40 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.***

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

**ADDITIONAL EMPLOYMENT INFORMATION**  
(Continuation from Page 5)

<b>Employer's Name</b>	Supervisor's Name	Supervisor's Telephone No. <i>(include area code)</i>	
Mailing Address	City	State	ZIP Code
Job Title and Type of Work			

Date Work Started (MM/DD/YYYY)	Date Work Ended (if ended) (MM/DD/YYYY) <input type="checkbox"/> Still working	Rate of Pay \$ _____ per _____	Hours Worked per Week (on average)
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