

[State Letterhead]

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Please give us the name of someone who can help you with your claim, such as a relative, friend, or neighbor. Giving us the name of a someone, other than your doctors, who knows about your condition may help us to make a decision on your claim. If you do not want to identify someone else who can help you with your claim, please check the box below.

It is important that you provide this information to us by {clmt_form_return_date}. You may respond by calling us or completing and returning this form. You may use the enclosed return envelope or fax your completed form to us at <Admin DMA fax Number>.

If you do not respond by {clmt_form_return_date}, we may decide your case based on the evidence we already have in file. This means we could find that you are not disabled based on our rules or that your disability has ended if you are already getting benefits.

If You Have Any Questions

If you have any questions or wish to provide more information, please call us at the number(s) shown below Monday - Friday between [local_office_open] and [local_office_close]. When you call or leave a message, please provide the Case ID: [case_id], your name, <if primary recipient is NOT claimant>[Clmt Full Name]'s name, <endif> and a call back number.

COMPLETE AND RETURN THIS FORM BY {clmt_form_return_date},

Name of Contact Person _____

Relationship to You _____

Address _____

City _____ State _____ Zip _____

Phone Number _____

Signature _____ Date _____

I do not want to identify someone else who can help with my claim.

Thank you for your help.

[Standard Signature Block]

[Standard CC Block]