SOCIAL SECURITY ADMINISTRATION

Form Approved
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
NAME OF WAGE EARNER OR SELF-EMPLOYED PERSON (If different from Claimant)	SOCIAL SECURITY NUMBER

SPOUSE'S NAME AND SOCIAL SECURITY NUMBER (COMPLETE ONLY IN SUPPLEMENTAL SECURITY INCOME CASE)

☐ FO Code _____
☐ Benefit Continuation
☐ 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):

CHECK BLOCK 1 AND THE STATEMENTS THAT APPLY **OR** CHECK BLOCK 2.

☐ 1. I (and/or my representative) wish to appear at a face-to-face 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 provide one at no cost to you.)

OR

☐ 2. I do not wish to appear nor do I wish a representative to appear for me at the disability hearing. I have been advised of my right to have a disability hearing. I understand that a disability hearing will give me a chance to present witnesses. It will also let me explain to the disability hearing officer why my disability benefits should not end. I understand that this chance to be seen and heard could help the disability hearing officer learn about the facts in my case. The disability hearing officer would give me a chance to have people who know about my condition give information and explain how my condition keeps me from working and restricts my activities. I have been told about my right to representation at the disability hearing, including representation by an attorney or other person of my choice. Although the above has been explained to me, I do not want to appear at at 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.

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.

EITHER THE CLAIMANT OR REPRESENTATIVE SHOULD SIGN - ENTER ADDRESSES FOR BOTH

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

Witnesses are required ONLY if this form has been signed by mark (X). If signed by mark (X), two witnesses to the signing who know the person requesting reconsideration must sign below, giving their full addresses.

1. SIGNATURE OF WITNESS	2. SIGNATURE OF WITNESS
ADDRESS (NUMBER AND STREET, CITY, STATE, ZIP CODE)	ADDRESS (NUMBER AND STREET, CITY, STATE, ZIP CODE)

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DHU SCHEDULING

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