REQUEST FOR RECONSIDERATION - DISABILITY CESSATION - RIGHT TO APPEAR					FOR SOCIAL SECURITY OFFICE USE ONLY (DO NOT WRITE IN THIS SPACE)			
·	IDE FOR PAPERWORK/F	PRIVACY ACT NOTION						
NAME OF CLAIMA	NT		SOCIAL SECUP	RITY NUMBER				
NAME OF WAGE E different from Clair	ARNER OR SELF-EMPLOYE nant)	ED PERSON (If	SOCIAL SECUP	RITY NUMBER				
	AND SOCIAL SECURITY NECURITY INCOME CASE)	ONLY IN	Benefit Co					
					For	eign Languag	e Notice	
TYPE OF DISABILITY						SSI		
BENEFIT	WORKER	WIDOW	CHILD	DISAE	BILITY	BLIN	D	CHILD
reasons are (reas	E WITH THE DETERMINATIONS should relate to the loce of the determination arlier. Include the date of	basis for stopping on your claim is dat	lisability benet ed more than	fits and be as	specific	as possible	e):	·
I AM SUBMITTIN	IG THE FOLLOWING AD	DITIONAL INFORMA	ATION (If "NO	NE" write "N	ONE") (A	Attach addit	ional page i	f needed):
CHECK BLOCK 1	AND THE STATEMENT	S THAT APPLY OF	R CHECK BL	OCK 2.				
	y representative) wish to a earing officer and it will let						n a person cal	led a
	an interpreter at the disabi need an interpreter, SSA v							
disability he disability he disability he about my c about my rithe above he prefer to he obtained by writing of a	sh to appear nor do I wish caring. I understand that a caring officer why my disable aring officer learn about the ondition give information a ght to representation at the last been explained to me, I have the disability hearing of the Social Security Adminated the control of the social Security Adminated the control of the social Security Adminated the control of the social Security Adminated the social Security Sec	disability hearing will onlity benefits should not be facts in my case. The facts in my case. The desplain how my core disability hearing, incompleted do not want to appeal ficer decide my case on istration. I have been his case, I can make the	give me a chance of end. I understhe disability hean dition keeps muluding represent rat a disability in the evidence advised that if it e request with a	te to present water that this tring officer wo for the form working tation by an at hearing, or havin my file, plus I change my many Social Section.	vitnesses. chance to could give a gand rest torney or ve someor any evid ind, I can urity offic	It will also lobe seen and me a chance ricts my active other person ne represent rence that I surequest a dise.	et me explain heard could to have peop vities. I have of my choice me at a disability hearin hearing hearing the me at a disability hearing the sability hearing heard could be sability hearing heart h	to the help the le who know been told e. Although lilty hearing. I may be g prior to the
true and correct to	the best of my knowledge. or causes someone else to	I understand that any do so, commits a crim	one who knowi e and may be s	ngly gives a fa ent to prison, o	lse or mis or may fa	sleading state ce other pena	ment about a Ilties, or both	material fact
CLAIMANT SIGNA		ANT OR REPRESENTAT		IGN - ENTER A RE OR NAME C				
CLAIMANT SIGNA	IURE		SIGNATOR	RE OR NAIVIE C	OF CLAIIVI	ANT 5 REPRE	SENTATIVE	
STREET ADDRESS.			REPRESEN	REPRESENTATIVE'S ADDRESS				
CITY	S	TATE ZIP CODE	CITY			STA	ATE ZII	CODE
TELEPHONE NUME	BER	DATE	TELEPHON	IE NUMBER			DATE	
	red ONLY if this form has I			mark (X), two	witnesse	s to the signi	ng who know	the person
requesting reconsideration must sign below, giving their full addresses.  1. SIGNATURE OF WITNESS				2. SIGNATURE OF WITNESS				
ADDRESS (NUMBE	R AND STREET, CITY, ST	ATE, ZIP CODE)	ADDRESS	(NUMBER ANI	D STREET	, CITY, STA	TE, ZIP CODE	)

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REQUEST FOR RECONSIDERATION - DISABILITY CESSATION - RIGHT TO APPEAR					FOR SOCIAL SECURITY OFFICE USE ONLY (DO NOT WRITE IN THIS SPACE)			
	IDE FOR PAPERWORK/F		CE)					
NAME OF CLAIMANT SOCIAL SECURITY NUMBER								
NAME OF WAGE E different from Clair	ARNER OR SELF-EMPLOYE	ED PERSON (If	SOCIAL SECUP	RITY NUMBER	•			
SDOUISE'S NAME	AND SOCIAL SECURITY N	JUMPER (COMPLETE	ONLY IN		☐ FC	O Code	_	
	ECURITY INCOME CASE)	NOWBER (COMPLETE)	ONLY IN		Benefit Continuation			
					Fc	reign Languaç	ge Notice	
TVDE OE				SSI				
TYPE OF DISABILITY BENEFIT WORKER WIDOW C			CHILD	DISAB	BILITY BLIND CHILD			
I DO NOT AGRE	WITH THE DETERMINA	ATION TO STOP DIS	ABILITY BENI	FEITS AND L	REQUE	ST RECONS	IDFRATION	Mv
NOTE: If the not	cons should relate to the ice of the determination arlier. Include the date o	on your claim is dat	ed more than					king this
I AM SUBMITTIN	IG THE FOLLOWING AD	DITIONAL INFORMA	ATION (If "NO	NE" write "N	ONE")	(Attach addi	tional page i	f needed):
CHECK BLOCK 1	AND THE STATEMENT	S THAT APPLY OF	R CHECK BL	OCK 2.				
	y representative) wish to a earing officer and it will let						h a person cal	led a
(If you	an interpreter at the disabi u need an interpreter, SSA							
OR								
disability he disability he disability he about my cabout my rethe above he prefer to he obtained by	sh to appear nor do I wish bearing. I understand that a caring officer why my disable aring officer learn about the ondition give information a light to representation at the last been explained to me, I have the disability hearing of the Social Security Admin a decision in my case. In the	disability hearing will only benefits should not be facts in my case. If not explain how my core disability hearing, include not want to appear ficer decide my case on istration. I have been	give me a chance of end. I unders the disability heat of the disability heat of the disability is at a disability in the evidence advised that if I	e to present water that this or the control of the	vitnesses chance to culd give g and res torney o re some any evic ind, I cal	s. It will also loto be seen and me a chance stricts my action of the person one represent dence that I so nequest a di	let me explain I heard could to have peopl vities. I have I of my choice me at a disabl ubmit or that	to the help the le who know been told . Although lity hearing. I may be
true and correct to	alty of perjury that I have of the best of my knowledge tion, or causes someone el	. I understand that any	yone who know	ingly gives a fa	alse or m	nisleading stat	ement about a	a material
		ANT OR REPRESENTA	TIVE SHOULD S	IGN - ENTER A	DDRES	SES FOR BOT	Н	
CLAIMANT SIGNA	TURE		SIGNATUF	RE OR NAME O	F CLAIN	MANT'S REPR	ESENTATIVE	
STREET ADDRESS.			REPRESEN	REPRESENTATIVE'S ADDRESS				
CITY	S	TATE ZIP CODE	CITY			ST	ATE ZII	CODE
TELEPHONE NUME	BER	DATE	TELEPHON	ie number			DATE	
	ired ONLY if this form has			mark (X), two	witness	ses to the sign	ing who knov	the person
requesting reconsideration must sign below, giving their full addresses.  1. SIGNATURE OF WITNESS				2. SIGNATURE OF WITNESS				
ADDRESS (NUMBE	R AND STREET, CITY, ST	ATE, ZIP CODE)	ADDRESS	(NUMBER AND	) STREE	T, CITY, STA	TE, ZIP CODE	)

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REQUEST FOR RECONSIDERATION - DISABILITY CESSATION - RIGHT TO APPEAR					FOR SOCIAL SECURITY OFFICE USE ONLY (DO NOT WRITE IN THIS SPACE)			
(SEE REVERSE SIDE FOR PAPERWORK/PRIVACY ACT NOTICE)								
NAME OF CLAIMA		SOCIAL SECUP	RITY NUMBER					
NAME OF WAGE E different from Clain	ARNER OR SELF-EMPLOYI nant)	SOCIAL SECUP	RITY NUMBER					
SPOUSE'S NAME	AND SOCIAL SECURITY 1	NUMBER (COMPLETE	ONLY IN		FO C	ode		
	ECURITY INCOME CASE)	VOINIBERT (OOIVIII EETE	ONET III		Benef	fit Continuation		
					Foreig	Foreign Language Notice		
TYPE OF		DISABILITY		-		SSI		
BENEFIT	WORKER	] WIDOW [	CHILD	DISAB	BILITY	BLIND	CHILD	
reasons are (reas NOTE: If the noti	E WITH THE DETERMIN, ons should relate to the ce of the determination arlier. Include the date	basis for stopping on your claim is da	disability benef ted more than	fits and be as	specific a	s possible):	,	
I AM SUBMITTIN	IG THE FOLLOWING AD	DITIONAL INFORM	ATION (If "NO	NE" write "N	ONE") (At	tach additional p	page if needed):	
CHECK BLOCK 1	AND THE STATEMENT	S THAT APPLY O	R CHECK BL	OCK 2.				
	y representative) wish to a earing officer and it will let						son called a	
	an interpreter at the disabi need an interpreter, SSA							
OR								
disability he disability he disability he about my ri about my ri the above h prefer to ha obtained by	sh to appear nor do I wish paring. I understand that a saring officer why my disal earing officer learn about the ondition give information at the passion of the disability hearing of the Social Security Admir decision in my case. In the	disability hearing will bility benefits should not be facts in my case. The disability hearing, in do not want to appear ficer decide my case distration. I have been	give me a chance of end. I unders the disability head on disability head of the cluding representate a disability on the evidence of advised that if I	e to present watend that this oring officer wo from working tation by an atthearing, or having thange my mile, plus change my mi	itnesses. In the control of the cont	t will also let me ever seen and heard ever chance to have exts my activities. Ther person of my represent me at a ce that I submit o	explain to the could help the epeople who know I have been told choice. Although disability hearing. I r that may be	
true and correct to	alty of perjury that I have on the best of my knowledge tion, or causes someone el	. I understand that ar	nyone who know	ingly gives a fa	lse or misle	eading statement	about a material	
	ANT OR REPRESENTATIV	E SHOULD SIGN - EN						
CLAIMANT SIGNA	TURE		SIGNATUF	RE OR NAME O	F CLAIMAN	NT'S REPRESENTA	ATIVE	
STREET ADDRESS.			REPRESEN	REPRESENTATIVE'S ADDRESS				
CITY	S	TATE ZIP CODE	CITY			STATE	ZIP CODE	
TELEPHONE NUMB	ER	DATE	TELEPHON	IE NUMBER		DATE		
	red ONLY if this form has I			mark (X), two	witnesses t	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	ADDRESS (NUMBER AND STREET, CITY, STATE, ZIP CODE)				

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			CF)						
(SEE REVERSE SIDE FOR PAPERWORK/PRIVACY ACT NOTICE)  NAME OF CLAIMANT SOCIAL SECURITY									
NAME OF WAGE E	ARNER OR SELF-EMPLOY	ED PERSON (If	SOCIAL SECUR	RITY NUMBER					
different from Clair	mant)	·							
					□ EO Codo				
	AND SOCIAL SECURITY I	NUMBER (COMPLETE	ONLY IN		FO Code				
SUPPLEMENTAL S	ECURITY INCOME CASE)				Benefit Continuation				
				1	Foreign Langua	age Notice			
TYPE OF DISABILITY			<u></u>		SSI				
BENEFIT	WORKER	WIDOW	CHILD	DISA	ABILITY BLIND CHILD				
reasons are (reas	E WITH THE DETERMIN sons should relate to the ice of the determination arlier. Include the date	basis for stopping of basis for stopping of the basis for stopping of the basis for stopping of the basis for stopping of the basis for stopping of the basis basis for stopping of the basis basis for stopping of the basis	disability bene ted more than	fits and be as	specific as possib	le):			
I AM SUBMITTIN	NG THE FOLLOWING AD	DDITIONAL INFORMA	ATION (If "NO	NE" write "N	ONE") (Attach add	litional page if needed):			
CHECK BLOCK 1	AND THE STATEMENT	TS THAT APPLY <u>O</u>	R CHECK BL	OCK 2.					
1. I (and/or m	y representative) wish to a earing officer and it will let	ppear at a face-to-face me explain why I do n	e disability hearing	ng. The disabil	ity hearing will be w	th a person called a			
☐ I need	an interpreter at the disab need an interpreter, SSA	ility hearing - Language	e		<u>·</u>				
UK									
disability h disability h disability h about my c about my r the above prefer to h obtained b	earing. I understand that a earing officer why my disal earing officer learn about the condition give information a ight to representation at the nas been explained to me, ave the disability hearing of	disability hearing will bility benefits should not facts in my case. The facts in my case. The disability hearing, included in the disability hearing, included in the fact of	give me a chang ot end. I unders he disability hea ndition keeps m cluding represen ar at a disability on the evidence advised that if	ce to present watend that this aring officer wo e from working tation by an athearing, or hav in my file, plus I change my m	ritnesses. It will also chance to be seen ar buld give me a chance and restricts my actorney or other perso e someone represent any evidence that I and, I can request a common to the control of th	nd heard could help the e to have people who know tivities. I have been told on of my choice. Although t me at a disability hearing. I			
true and correct to	alty of perjury that I have e the best of my knowledge. or causes someone else to	I understand that any	one who knowi	ngly gives a fa	lse or misleading sta	tement about a material fact			
	EITHER THE CLAIMA	ANT OR REPRESENTA	TIVE SHOULD S	IGN - ENTER A	DDRESSES FOR BO	ГН			
CLAIMANT SIGNA	TURE		SIGNATU	RE OR NAME C	F CLAIMANT'S REP	RESENTATIVE			
STREET ADDRESS.			REPRESEN	ITATIVE'S ADI	DRESS				
CITY	S	TATE ZIP CODE	CITY		S	TATE ZIP CODE			
TELEPHONE NUME	BER	DATE	TELEPHON	NE NUMBER		DATE			
	red ONLY if this form has l eration must sign below, g			mark (X), two	witnesses to the sig	ning who know the person			
1. SIGNATURE OF WITNESS				2. SIGNATURE OF WITNESS					
ADDRESS (NUMBER AND STREET, CITY, STATE, ZIP CODE)			ADDRESS	ADDRESS (NUMBER AND STREET, CITY, STATE, ZIP CODE)					

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