Form Approved
OMB No. 0960-0045

SOCIAL SECURITY ADMINISTRATION

STATEMENT OF CLAIMANT OR OTHER PERSON

NAME OF WAGE EARNER, SELF-EMPLOYED PERSON, OR SSI CLAIMANT	SOCIAL SECURITY NUMBER
STATEMENT (Complete with above wage earner, self-employed person, or SSI claimant)	RELATIONSHIP TO WAGE EARNER, SELF-EMPLOYED PERSON, OR SSI CLAIMANT

Understanding that this statement is for use by the Social Security Administration, I hereby certify that-

I have been advised of my right to elect to have my disability benefits and Medicare, if applicable, continued to me, pending the outcome of my appeal of the decision that my disability has ceased. I understand that benefits can also be continued to everyone qualified on my Social Security record whom I have specified below.

I understand that if I lose my appeal, I will be asked to pay this money back, including all checks received after my period of disability ended (2 months after the cessation date), through the month such benefits were received if the appeal is not decided in my favor.

I have the right to ask that I not have to pay the money back. If I do ask, and if it is determined by SSA that my appeal was made in good faith and that I need my income and resources for ordinary and necessary living expenses or that other factors apply, I will not have to pay the money back. I also understand that SSA will provide me with more information about waiver of recovery of an overpayment, if I would like it.

I will not be asked to pay back any Medicare benefits I receive while my appeal is being decided.

If I win my appeal, any money I am owed will be paid.

While my appeal is pending and my benefits are being continued, I agree to report promptly to Social Security any changes which may affect my right to receive benefits, such as work activity or any change in the status of dependents receiving benefits on my record.

I understand that if I turn down continued benefits during the specified 10-day period after the initial cessation, I will not have the chance (if the 10-days have passed) to elect continued benefits again until I get the notice of the reconsideration decision on my disability appeal.

I understand that if I do not elect continued benefits when I request reconsideration, but later request a hearing before an administrative law judge (ALJ) and elect continued benefits until an ALJ decision is made, that continued benefits may be paid no earlier than the month of the reconsideration determination or the month of election, whichever is later.

Election:

- [x] I want benefits continued for me and everyone receiving benefits on my Social Security record.
- [ ] I want only my benefits continued.
- [ ] I want benefits continued for myself and the following eligible individuals receiving benefits on my Social Security record (specify): _____
- [ ] I do not want any benefits continued.

☐ I want Medicare coverage for myself and anyone else qualified on my Social Security record, but I do not want any disability benefit payments. I understand that I will be billed directly for the Supplemental Medical Insurance coverage (Medicare Part B), and if payment is not made, the coverage will be terminated.

☑ I want both Part A (hospital insurance) and Part B Medicare coverage continued.

☐ I want only Part A Medicare coverage continued.

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it.

Explanations about these and other reasons why information you provide to us may be used or given out are available in Social Security Offices. If you want to learn more about this, contact any Social Security Office.

The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB control number.

TIME IT TAKES TO COMPLETE THIS FORM

We estimate that it will take you about 15 minutes to complete this form. This includes the time it will take to read the instructions, gather the necessary facts and fill out the form. If you have comments or suggestions on this estimate, or on any other aspect of this form, write to the Social Security Administration, ATTN: Reports Clearance Officer, 1-A-21 Operations Bldg., Baltimore, MD 21235-0001. **Send only comments relating to our "time it takes" estimate to the office listed above. All requests for Social Security cards and other claims-related information should be sent to your local Social Security office, whose address is listed under Social Security Administration in the U.S. Government section of your telephone directory.**

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 statement about a material fact in this information, or causes someone else to do so, commits a crime and may be subject to a fine or imprisonment.

SIGNATURE OF PERSON MAKING STATEMENT

Signature *(First name, middle initial, last name) (Write in ink)*	Date *(Month, day, year)*
	Telephone Number *(Include Area Code)*

Mailing Address *(Number and street, Apt. No.,P.O.Box, Rural Route)*

City and State	ZIP Code

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

1. Signature of Witness	2. Signature of Witness
Address *(Number and street, City, State, and ZIP Code)*	Address *(Number and street, City, State, and ZIP Code)*