Form Approved OMB No. 0960-0015

REQUEST FOR WITHDRAWAL OF APPLICATION

IMPORTANT NOTICE - This is a request to cancel your application. If we approve it, the decision we made on your application will have no legal effect. You will forfeit all rights attached to an application, including the rights of appeal. You will have to return any payment we made to you or anyone else on the basis of that application. You must then reapply if you want a determination of your Social Security rights at any time in the future. Any subsequent application may not involve the

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resulted, or will result, i	n a disadvantage to you. Yo w, this procedure will help yo	our local Soci						
NAME OF WAGE EARNER	R, SELF-EMPLOYED INDIVIDUA	AL, OR ELIGIBL	E INDIVIDUAL	SOCIAL SEC	ECURITY NUMBER			
IF DIFFERENT, PRINT	st name)	YOUR SOCIAL SECURITY NUMBER						
TYPE OF BENEFIT YOU	J WANT TO WITHDRAW	DATE OF AF	PPLICATION		F APPLICABLE, DO YOU WANT TO KEEP MEDICARE BENEFITS? Yes No			
request may not be entitlement has been persons whose bene withdrawn and all rel	withdrawal of my application cancelled after 60 days made, there must be repaired by affected material will remain ect the proper crediting of	from the many syment of all sust consent a part of the	ailing of notice benefits paid or to this withdra se records of the	of approval; n the applica awal. I furthe ne Social Se	and (2) if a detion I want without the contract the curity Administract	eterminat drawn, an hat the a ration and	tion of my and all other application d that this	
Give reason for withdr	awal. (If you need more s	pace, use the	e reverse of this	form.)				
	ontinue working. (I have be ge and still wish to withdra			es to withdra	awal for applican	ts under	full	
2. Other (Pleas	e explain fully):							
						ntinued o	on reverse	
	SIGNATU	RE OF PERS	SON MAKING F	REQUEST				
Signature (First name, mid	ddle initial, last name) (Write in in	ık)			Date (Month, day, year)			
SIGN HERE				Telephone Number (include area code)			rea code)	
Mailing Address (Number a	nd Street, Apt. No., P.O. Box, or	Rural Route)						
City and State	ZIP Code	Enter Name of	Enter Name of County (if any) in which you now live					
	red ONLY if this request							
Signature of Witness	2. Signature of Witness							
Address (Number and Stre	Address (Number and Street, City, State and ZIP Code)							
	FOR USE OF	SOCIAL SE	CURITY ADMII	VISTRATION	V			
APPROVED	APPROVED NOT APPROVED BENEFITS NOT CONSENT(S) NOT OTHER (Attach special determination) OTHER (Attach special determination)							
SIGNATURE OF SSA E	TITLE			DATE				
			CLAIMS AUTHORIZ	ER	OTHER (Specify)			

Additional Remarks:							

Privacy Act Statement

Collection and Use of Personal Information

Sections 202 (a), 205 (a), and 1872 of the Social Security Act, as amended, authorize us to collect this information. The information you provide will be used to cancel your application for benefits.

The information you furnish on this form is voluntary. However, failure to provide the requested information may cause continued consideration of your benefits claim.

We rarely use the information you supply for any purpose other than for cancelling an application. However, we may use it for the administration and integrity of Social Security programs. We may also disclose information to another person or to another agency in accordance with approved routine uses, which include but are not limited to the following:

- 1. To enable a third party or an agency to assist Social Security in establishing rights to Social Security benefits and/or coverage;
- 2. To comply with Federal laws requiring the release of information from Social Security records (e.g., to the Government Accountability Office and Department of Veterans' Affairs);
- 3. To make determinations for eligibility in similar health and income maintenance programs at the Federal, state and local level; and
- 4. To facilitate statistical research, audit or investigative activities necessary to assure the integrity of Social Security programs.

We may also use the information you provide in computer matching programs. Matching programs compare our records with records kept by other Federal, state, or local government agencies. Information from these matching programs can be used to establish or verify a person's eligibility for Federally funded or administered benefit programs and for repayment of payments or delinquent debts under these programs.

Additional information regarding this form, routine uses of information, and our programs and systems, is available on-line at www.ssa.gov or at your local Social Security office.

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 control number. We estimate that it will take about 5 minutes to read the instructions, gather the facts, and answer the questions. SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. You can find your local Social Security office through SSA's website at www.socialsecurity.gov. Offices are listed under U.S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213 (TTY 1-800-325-0778). You may send comments on our time estimate above to: SSA, 6401Security Blvd., Baltimore, MD 21235-6401. Send only comments relating to our time estimate to this address, not the completed form.