Statutory Benefit Continuation Election Statement

INSTRUCTIONS FOR COMPLETING FORM SSA-792

Keep a copy of this form for your records.

This Form is Time Sensitive

If you want to continue to receive benefits pending the outcome of your request for appeal at the reconsideration or hearing level, we must receive this form no later than 15 calendar days from the date on the notice informing you of our determination ending disability benefits.

If you submit this form more than 15 calendar days from the date on the notice informing you of our determination ending disability benefits and ask to continue receiving benefits, please complete Section E. (Good Cause Statement) to explain why you are submitting the form late. We will review your reason for submitting the form late and determine if we can accept the late form. If we find you have a good reason, we will continue your benefits.

When To Complete This Form

You must have submitted (or must submit with this form) a request to appeal the determination to end your disability benefits because we determined you, or the number holder on whose record you receive benefits, are no longer disabled.

Complete This Form If Either of the Following Applies

- You want benefits continued during a medical reconsideration or hearing appeal, or
- You want to decline continuation of benefits during a medical reconsideration or hearing appeal.

Definition of Terms

Number Holder:
• A person who earns Social Security credits while working for wages or self-employment income. Sometimes referred to as the "Wage Earner" or "Worker."

Beneficiary:
• A person who is receiving Social Security payments either from their own record, or as a child, spouse,widow, or widower of the number holder.

Recipient:
• A person who is receiving Supplemental Security Income (SSI) payments.

Representative Payee:
• A person or entity appointed by Social Security to manage benefit payments for someone unable to manage or direct the management of their own benefits.

Who Should Complete and Sign This Form

To complete this form, you must be the beneficiary, SSI recipient, or their representative payee.

How to Submit This Form

Submit this form to your local Social Security office by mail or in person.

Complete each of the sections required for your case:

Section	Required For -
A	All forms
B	Disabled or blind Supplemental Security Income (SSI) recipient only
C	Disabled or blind beneficiary receiving benefits on their own earnings record or in addition to SSI.
D	Beneficiary receiving benefits on another person's earnings record only or in addition to SSI
E	All late forms
F	All forms

Privacy Act Statement
Collection and Use of Personal Information

Sections 223(g) and 1631(a)(7) of the Social Security Act, as amended, allow us to collect this information, which we will use to determine benefits eligibility. Providing this information is voluntary, but not providing all or part of the information may prevent us from assisting you with the request and may delay receipt of payments. As law permits, we may use and share the information you submit, including with other Federal agencies, contractors, and others, as outlined in the routine uses within System of Records Notices (SORN) 60-0089, 60-0090, 60-0103, and 60-0320, available at www.ssa.gov/privacy. The information you submit may also be used in computer matching programs to establish or verify eligibility for Federal benefit programs and to recoup debts under these programs

Paperwork Reduction Act Statement

This information collection meets the clearance 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 10 minutes to read the instructions, gather the facts, and answer the questions. You may send us your comments on our estimated completion time to **SSA, 6401 Security Blvd., Baltimore, MD 21235-6401**. Send only comments relating to our time estimate to this address, not the completed form.

References- Social Security Act Sections 223(g) and 1631 (a)(7), 20 CFR §404.1597, 404.1597(a), 416.995 and 416.996

Section A - Information about you (Beneficiary or Recipient)

Provide the following information about the beneficiary or recipient who is making an election about continuation of their benefits.

Social Security Number	Telephone Number

First Name	Middle Initial	Last Name

Address *(Street or PO Box. Include apartment number, if applicable)*

City	State	ZIP Code

IMPORTANT - If your disability benefits are suspended due to work activity at the time of our decision that your medical condition no longer meets the requirements to continue receiving benefits and you elect to continue benefits during the appeal of that decision:

1. You will receive benefits only for the months in which you do not have substantial work activity, and
2. Benefits end the earlier of the appeal decision or when the extended period of eligibility ends because of your work activity.

Section B - SSI-Only Recipient Benefit Continuation Election Options

Complete this section if you receive or are filling out the form on behalf of someone who receives SSI benefits only. If you receive both SSI and Social Security disability insurance benefits, skip to Section C.

Choose one option:

- ☐ I do not want my SSI payments continued.
- ☐ I want my SSI payments continued.

Section C - Number Holder Benefit Continuation Election Options

Complete this section if you receive disability benefits based on your own earnings record only (i.e., you are the number holder of the earnings record from which disability benefits are issued) ***or*** *you receive both on your earnings record and SSI* ***or*** *you are filling out the form on behalf of such individual. For SSI only, complete section B above. For beneficiaries receiving benefits from someone else's earning's record, skip to section D.*

Choose one option:

- ☐ I do not want any benefits continued.
- ☐ I want all my benefits continued, including SSI (if receiving from both programs) for me and everyone else receiving benefits on my record (if applicable).
- ☐ I want all my benefits continued, including SSI (if receiving from both programs), but I do not want benefits continued for everyone else receiving benefits on my record.
- ☐ I want all benefits continued for myself including SSI (if receiving from both programs). I want only the following entitled individuals to receive benefits during my appeal. Specify name(s):

  _____

- ☐ I want only Medicare coverage for myself, but I do not want monthly disability benefit payments. I understand that, if enrolled, I will be billed directly for Supplementary Medical Insurance coverage, and that coverage will be terminated if payment is not made. If this is elected, you must also select one of the following:

  ☐ Both Part A and Part B Medicare coverage (if enrolled in both) ☐ Part A Medicare coverage only.

- ☐ I want only Medicare coverage for myself **and** anyone else qualified on my record, but I do not want any disability benefit payments. I understand that will be billed directly Supplementary Medical Insurance coverage, and that coverage will be terminated if payment is not made. If this is elected, you must also select one of the following:

  ☐ Both Part A and Part B Medicare coverage (if enrolled in both) ☐ Part A Medicare coverage only.

Section D - Spouse, Widow, or Child Benefit Election Options

Complete this section if the beneficiary or recipient (named in section A) is the child, spouse, or widow(er) of the number holder.

Number Holder Social Security Number	Number Holder First Name	Middle Initial	Number Holder Last Name

Choose one option:

- ☐ I do not want any benefits continued.
- ☐ I want all my benefits continued, including Medicare (if applicable).
- ☐ I want only Medicare coverage (if applicable), but I do not want any benefit payments. I understand that I will be billed directly for Supplementary Medical Insurance coverage, and that coverage will be terminated if payment is not made. If this is elected, you must also select one of the following:
  - ☐ Both Part A and Part B Medicare coverage (if enrolled in both).
  - ☐ Part A Medicare coverage only.

Section E - Good Cause Statement

Complete this section if you want your benefits continued and if you are submitting this form more than 15 calendar days from the date on the notice informing you of our determination ending disability benefits. Explain the reason you did not submit the request for benefit continuation within 15 calendar days. If we determine you have good reason for the untimely request, we will accept your election request and continue your benefits.

Section F - Required Signature

We cannot continue your benefits unless you complete this section.

I understand that if I do not elect for benefits to continue when I request reconsideration, I will not have another chance to elect continued benefits again until I get the notice of reconsideration decision on my disability appeal.

I understand that if I do not elect for benefits to continue when I request reconsideration, but elect continued benefits when I request a hearing before an administrative law judge, continued benefits will begin the later of the month of the reconsideration determination or the month I submit this election.

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 changes in the status of dependents receiving benefits on my record.

By signing this form, I attest that I understand if my appeal is unsuccessful, the payments I receive during appeal will be considered an overpayment, and I will be asked to pay the money back. I understand that I can ask for SSA not to collect the payments received during the appeal by submitting a Request for Waiver of Overpayment Recovery Form SSA-632-BK. If SSA approves my request, I will not have to repay these payments. I will not be asked to pay back any Medicare benefits I receive while my appeal is being decided, if applicable.

I declare under penalty of perjury that I have examined all the information on this form, and any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly makes 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 Election (beneficiary, SSI recipient, or representative payee)
To be completed by individual in section A or the representative payee for that individual.

Signature	Date (MM/DD/YYYY)
If completed by representative payee, print name here:	Telephone Number

If completed by representative payee, check box here: ☐

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

City	State	ZIP Code

FOR SOCIAL SECURITY OFFICE USE (DO NOT WRITE IN THIS SPACE):

Date Received:	Benefit Continuation	☐ Approved	☐ Denied
Good Cause for Late Filing	☐ Yes	☐ No	☐ N/A