Print Claimant Copy

NOTICE REGARDING SUBSTITUTION OF PARTY UPON DEATH OF CLAIMANT RECONSIDERATION OF DISABILITY CESSATION

Print DHU Copy

Name of Deceased Claimant	Claim For
Wage Earner's Name (Leave blank if same as above)	Social Security Number

I have been informed that the claimant had requested reconsideration of a disability cessation but died before action on the request was completed. I understand that the deceased claimant's request for reconsideration of disability cessation may not be processed unless an eligible person is substituted. My relationship to the deceased claimant.

Print Claims File Copy

☐ Widow/Widower ☐ Surviving Divorced Spouse

If you have checked either of the above boxes and have in your care the deceased's child (children) who is (are) under age 18 (or an eligible student) or disabled, check here ☐

Print Other Copy

☐ Child ☐ Disabled Child ☐ Parent ☐ Administrator/Executor of Estate

☐ Other (Describe) _____

Complete Either 1 or 2

☐ 1. I wish to be made a substitute party and to proceed with the reconsideration of a disability cessation requested by the deceased.

Check Block(s) that Apply

If the Social Security Administration decides that a hearing is necessary

☐ a. I want the disability hearing as already scheduled

☐ b. I want a hearing but request a later time or different location (specify number of days, location desired)

_____

☐ c. I do not want to appear at the hearing by video teleconference. Please schedule the hearing so that I may appear in person.

☐ d. I do not want a hearing, and I request a decision on the evidence of record.

☐ 2. I do not wish to proceed with the reconsideration of a disability cessation requested by the deceased, and I hereby request withdrawal of the deceased's request for reconsideration of a disability cessation. I have had a full explanation of the effects of a withdrawal.

Signature (First Name, Middle Initial, Last Name)	Date (MM/DD/YYYY)
	Telephone Number (Include Area Code)

Print or Type Full Name

Mailing Address (Number and Street Address, P.O. Box or Rural Route)

City, State	ZIP Code

Witnesses are required only if this form has been signed by mark (X) above. 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)

Privacy Act Statement
Collection and Use of Personal Information

Section 205(b) of the Social Security Act, as amended, allows us to collect this information. Furnishing us this information is voluntary. However, failing to provide all or part of the information may prevent and accurate and timely decision on any claim filed, or could result in loss of benefits.

We will use the information you provide to determine a substitute party and pursue an appeal on behalf of a deceased claimant. We may also share your information for the following purposes, called routine uses:

- To student volunteers, individuals working under a personal services contract, and other workers who technically do not have the status of Federal employees, when they are performing work for us, as authorized by law, and they need access to personally identifiable information (PII) in our records in order to perform their assigned agency functions; and

- To contractors and other Federal Agencies, as necessary, for the purpose of assisting us in the efficient administration of our programs. We will disclose information under this routine use only in situations in which we may enter into a contractual or similar agreement with a third party to assist in accomplishing an SSA function relating to this system of records.

In addition, we may share this information in accordance with the Privacy Act and other Federal laws. For example, where authorized, we may use and disclose this information in computer matching programs, in which our records are compared with other records to establish or verify a person's eligibility for Federal benefit programs and for repayment of incorrect or delinquent debts under these programs.

A list of additional routine uses is available in our Privacy Act System of Records Notice (SORN) 60-0089, entitled Claims Folders System, as published in the Federal Register (FR) on October 31, 2019, at 84 FR 58422 and 60-0320, entitled Electronic Disability (eDIB) Claim File, as published in the FR on June 4, 2020, at 85 FR 34477. Additional information, and a full listing of all our SORNs, is available on our website at www.ssa.gov/privacy/.

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 (OMB) control number. We estimate that it will take about 5 minutes to read the instructions, gather the facts, and answer the questions. ***Send only comments relating to this burden estimate or any other aspect of this collection, including suggestions for reducing this burden to:*** *SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.*

Print Claimant Copy | Print DHU Copy | Print Claims File Copy | Print Other Copy

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