Request for Reinstatement - Title II

Claimant's Name	Social Security Number

I request reinstatement of my Social Security Disability Benefits. I am disabled and my impairment is the same as (or related to) the impairment which was the basis for my prior entitlement. I am not performing substantial gainful activity (SGA) and my medical condition prevents me from performing SGA.

I understand that I may be able to receive provisional (temporary) benefits while my request for reinstatement is being decided.

For persons who have extended Medicare coverage:

I understand that my Medicare coverage (Part A hospital insurance and Part B medical insurance) could terminate if my request for reinstatement is denied.

For persons who do not have extended Medicare coverage:

I understand that my previous Medicare coverage will be effective with the start of my provisional payments. I understand that I may be charged a premium for Medicare Part B coverage.

For persons who are entitled to any other SSA benefits based on disability or blindness:

I understand that if SSA denies my request for reinstatement because I have medically improved, my current entitlement to SSA benefits will be reviewed and may terminate.

I declare under the 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 or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime and may be sent to prison, or may face other penalties, or both.

Signature	Date	Area Code and Telephone Number Where You can be reached During the Day

Address (Number and Street)	
City and State	ZIP Code

WITNESSES (Write in ink)

Witnesses are required ONLY if this request has been signed by mark (x) above. If signed by mark (x), two witnesses to the signing who knows the applicant 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)

THIS INFORMATION IS ONLY NEEDED IF YOUR PROVISIONAL BENEFITS WILL BE SENT TO YOUR PRIOR REPRESENTATION PAYEE
REPRESENTATIVE PAYEE (Write in ink)

Your Title or Relationship to the Claimant		Area Code and Telephone Number Where You Can Be Reached During the Day
Address (Number and Street)		
City and State		ZIP Code
Your full name (First name, middle initial, last name) **Please print here**	Signature **Please sign here**	Date

Privacy Act Statement
Collection and Use of Personal Information

Sections 223(i) 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 an accurate and timely decision on your disability claim filed.

We will use the information you provide to determine your eligible for the reinstatement of your prior benefits. We may also share the information for the following purposes, called routine uses:

- To employers, current or former, for correcting or reconstructing earnings records and for Social Security tax purposes; 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 assisting accomplishing an agency 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 Notices (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 of 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 2 minutes to read the instructions, gather the facts, and answer the questions. ***Send only comments regarding 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.*