REQUEST FOR WITHDRAWAL OF APPLICATION

Do not write in this space

IMPORTANT NOTICE - This is a request to withdraw 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 same retroactive period. We intend for you to use this procedure only when your decision to file has resulted, or will result, in a disadvantage to you. Your local Social Security office will be glad to explain whether, and how, this procedure will help you.

NAME OF WAGE EARNER, SELF-EMPLOYED INDIVIDUAL, OR ELIGIBLE INDIVIDUAL	SOCIAL SECURITY NUMBER
IF DIFFERENT, PRINT YOUR NAME (*First name, middle initial, last name*)	YOUR SOCIAL SECURITY NUMBER

TYPE OF BENEFIT YOU WANT TO WITHDRAW	DATE OF APPLICATION MM / DD / YYYY	IF APPLICABLE, DO YOU WANT TO KEEP MEDICARE BENEFITS? ○ Yes ○ No

I hereby request the withdrawal of my application, dated as above, for the reasons stated below. I understand that (1) this request may not be cancelled after 60 days from the mailing of notice of approval; and (2) if a determination of my entitlement has been made, there must be repayment of all benefits paid on the application I want withdrawn, and all other persons whose benefits would be affected must consent to this withdrawal. I further understand that the application withdrawn and all related material will remain a part of the records of the Social Security Administration and that this withdrawal will not affect the proper crediting of wages or self-employment income to my Social Security earnings record.

Give reason for withdrawal. *(If you need more space, use the reverse of this form.)*

1. ○ I intend to continue working. (I have been advised of the alternatives to withdrawal for applicants under full retirement age and still wish to withdraw my application.)

2. ○ Other (Please explain fully):

○ Continued on reverse

SIGNATURE OF PERSON MAKING REQUEST

Signature *(First name, middle initial, last name) (Write in ink)*	Date *(Month, day, year):* MM / DD / YYYY
SIGN HERE	Telephone Number *(include area code):*

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

City and State	ZIP Code	Enter Name of County (if any) in which you now live

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 know the person making the request 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)*

FOR USE OF SOCIAL SECURITY ADMINISTRATION

○ APPROVED	○ NOT APPROVED BECAUSE	○ BENEFITS NOT REPAID	○ CONSENT(S) OBTAINED	○ OTHER *(Attach special determination)*

SIGNATURE OF SSA EMPLOYEE	TITLE ○ CLAIMS ○ OTHER *(Specify)*	DATE MM / DD / YYYY

	AUTHORIZER	

Additional Remarks:

Privacy Act Statement
Collection and Use of Personal Information

Sections 202, 205, 223 and 1872 of the Social Security Act, as amended, allow us to collect this information. Furnishing us this information is voluntary. However, failing to provide us with all or part of the information may cause continued consideration of your benefits claim.

We will use the information you provide to cancel your application for benefits. We may also share your information for the following purposes, called routine uses:

- To student volunteers and other workers, who technically do not have the status of Federal employees, when they are performing work for Social Security Administration (SSA) as authorized by law, and they need access to personally identifiable information in SSA records in order to perform their assigned agency functions; and
- To contractors and other Federal agencies, as necessary, for the purpose of assisting SSA in the efficient administration of its programs.

In addition, we may share the 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 Systems, as published in the Federal Register (FR) on April 1, 2003, at 68 FR 15784. Additional information and a full listing of all our SORNs are 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 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.***