

REPORT OF NEW INFORMATION IN DISABILITY CASES
USE THIS FORM ONLY WHEN THERE IS A CHANGE TO BE REPORTED

PRINT NAME OF DISABLED PERSON OR PERSONS ABOUT WHOM REPORT IS MADE

SOCIAL SECURITY CLAIM NUMBER ON WHICH BENEFITS ARE PAID.

It is a nine digit number (000-00-0000) followed by a letter only or by a letter and a number (A, B, B2, C, C1, D, E, F, or H.) Your report cannot be processed without the correct claim number.

LETTER

DO YOU ALSO RECEIVE SSI OR BLACK LUNG BENEFITS? (Check one)

YES NO

1. CHANGE OF ADDRESS (Print new address at bottom)

If the Social Security Administration is sending your payments to your financial organization, do you wish this to continue?

YES NO

2. DISABLED PERSON'S CONDITION HAS IMPROVED OR PHYSICIAN HAS ADVISED THAT DISABLED PERSON CAN RETURN TO WORK.

3. DISABLED PERSON RETURNED TO WORK OR STOPPED WORK

MONTH, DAY, AND YEAR

(a) Disabled person began working on:

(b) Place and address of employment or self employment:

(c) Disabled person's total monthly earnings for each month are: (If an employee, enter each month's gross earnings. If self-employed, enter each month's net earnings and the number of hours worked in each month.)

Month:

Amount: \$ \$ \$ \$ \$ \$ \$

Hours:

MONTH, DAY, AND YEAR

(d) Disabled person is still working YES NO (If NO is checked, answer "e") (e) Disabled person stopped working on:

4. DISABLED PERSON LEFT CUSTODY OF REPRESENTATIVE PAYEE ON

MONTH, DAY, AND YEAR

Disabled person's present address:

5. DISABLED PERSON DIED ON

MONTH, DAY, AND YEAR

6. DISABLED PERSON GOING OUTSIDE THE U.S.

DATE GOING

NAME OF COUNTRY:

DATE EXPECTED TO RETURN

7. DISABLED PERSON MARRIED ON

DATE OF MARRIAGE

8. DISABLED PERSON IS RECEIVING WORKERS' COMPENSATION (INCLUDING BLACK LUNG BENEFITS) OR ANOTHER PUBLIC DISABILITY BENEFIT OR THE AMOUNT OF PRESENT PAYMENT HAS CHANGED.

(a) Lump sum payment of

\$

(b) Date of latest award

MONTH, DAY, AND YEAR

(c) Claim Number

NUMBER

(d) Change in periodic payment amount:

FROM \$

TO \$

9. Disabled person begins to receive a pension or annuity based on employment after 1956 not covered by Social Security, or cessation of such pension or annuity.

Beginning Date (Month/Year)

Ending Date (Month/Year)

10. Confinement as a result of a criminal offense in a jail, prison, or other penal institution, correctional facility, or certain mental health institutions.

DATE OF CONFINEMENT (MONTH, DAY, YEAR)

SIGNATURE OF PERSON MAKING THIS REPORT

NUMBER AND STREET, APARTMENT NO., P.O. BOX, OR RURAL ROUTE

CITY

STATE

ZIP CODE

DATE SIGNED

TELEPHONE NUMBER (If any)

ENTER NAME OF COUNTY, IF ANY, IN WHICH YOU LIVE

## HOW TO REPORT

There are three ways to report:

1. Phone Social Security and explain the change.
2. Visit any Social Security Office.
3. Mail this form to any Social Security Office.  
MAKE SURE YOU FILL IN THESE NECESSARY DETAILS ON THE REVERSE SIDE OF THIS FORM.

- NAME of disabled person about whom the report is made.
- The correct CLAIM NUMBER under which the benefits are payable.
- WHAT is being reported.
- DATE it happened.
- Your SIGNATURE and ADDRESS.

NOTE: REMEMBER TO TELL US WHEN YOU MOVE, EVEN IF YOUR MAILING ADDRESS FOR CHECKS HAS NOT CHANGED.

## IMPORTANT INFORMATION

PRIVACY ACT NOTICE: This report is authorized by 20 CFR 404.1588.

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it.

Explanations about these and other reasons why information you provide us may be used or given out are available in Social Security Offices. If you want to learn more about this, contact us at 1-800-772-1213 or at any Social Security Office.

## PAPERWORK REDUCTION ACT STATEMENT:

The **Paperwork Reduction Act of 1995** requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB control number. We estimate that it will take you about 5 minutes to complete this form. This includes the time it will take to read the instructions, gather the necessary facts and fill out the form.

All requests for Social Security cards and other claims-related information should be sent to your local Social Security office, whose address is listed under Social Security Administration in the U.S. Government section of your telephone directory.

## WHAT TO REPORT

The kinds of events that you must report to Social Security are listed on the other side of this form. The booklet, "What You Need To Know When You Get Disability Benefits," tells more about these reporting events. If you do not have this booklet or if you want help in making a report, get in touch with any Social Security Office and the people there will be glad to help you.

## FAILURE TO REPORT

If you do not report events as shown on this form, you may not be paid some or all of the benefits due you, or you may be overpaid, in which case, you will have to pay back any benefits you received that were not due you.

Also if you conceal or fail to disclose a reporting event with an intent to fraudulently obtain benefits either in a greater amount than is due or when no payment is authorized, you may be FINED, IMPRISONED, or both, as provided in section 208 of the Social Security Act.

## INFORMATION CONFIDENTIAL

The information furnished on this form will be used to determine if you are still eligible for Social Security disability benefits or if they should be changed. This information may be disclosed by Social Security to another person or to another agency for the following purposes:

- to assist Social Security in establishing the right of an individual to Social Security benefits and/or the amount of the benefits;
- to facilitate statistical research and audit activities necessary to assure the integrity and improvement of the programs administered by Social Security; and
- to comply with Federal laws requiring the exchange of information between Social Security and another agency, (such as the State Vocational Rehabilitation Agencies for rehabilitation services).

NOTE: USE THIS FORM ONLY IF YOU HAVE A CHANGE TO REPORT