SOCIAL SECURITY ADMINISTRATION TOE 420

Form Approved
OMB No. 0960-0015

REQUEST FOR WITHDRAWAL OF APPLICATION

Do not write in this space

IMPORTANT NOTICE.— This is a request to cancel your application. If it is approved, the decision we made on your application will have no legal effect, all rights attached to an application, including the rights of reconsideration, hearing, and appeal will be forfeited, and any payments we made to you or anyone else on the basis of that application will have to be returned. You must then reapply if you want a determination of your Social Security rights at any time in the future but any subsequent application may not involve the same retroactive period. This procedure is intended to be used 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	
PRINT YOUR NAME *(First name, middle initial, last name)*	DATE OF APPLICATION	TYPE OF BENEFIT
	TYPE OF APPLICATION	

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a determination of my entitlement has been made, there must be repayment of all benefits paid on the application I want withdrawn, and all other persons whose benefits would be affected must consent to this withdrawal. I further understand that the application withdrawn and all related material will remain a part of the records of the Social Security Administration and that this withdrawal will not affect the proper crediting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)*
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) NOT OBTAINED ☐ OTHER *(Attach special determination)*

SIGNATURE OF SSA EMPLOYEE	TITLE ☐ CLAIMS AUTHORIZER ☐ OTHER *(Specify)*	DATE

Additional Remarks:

Privacy Act Statement

Collection and Use of Personal Information

Sections 202 (a), 205 (a), and 1872 of the Social Security Act, as amended, authorize us to collect this information. The information you provide will be used to cancel your application for benefits.

The information you furnish on this form is voluntary. However, failure to provide the requested information may cause continued consideration of your benefits claim.

We rarely use the information you supply for any purpose other than for cancelling an application. However, we may use it for the administration and integrity of Social Security programs. We may also disclose information to another person or to another agency in accordance with approved routine uses, which include but are not limited to the following:

1. To enable a third party or an agency to assist Social Security in establishing rights to Social Security benefits and/or coverage;
2. To comply with Federal laws requiring the release of information from Social Security records (e.g., to the Government Accountability Office and Department of Veterans' Affairs);
3. To make determinations for eligibility in similar health and income maintenance programs at the Federal, state and local level; and
4. To facilitate statistical research, audit or investigative activities necessary to assure the integrity of Social Security programs.

We may also use the information you provide in computer matching programs. Matching programs compare our records with records kept by other Federal, state, or local government agencies. Information from these matching programs can be used to establish or verify a person's eligibility for Federally funded or administered benefit programs and for repayment of payments or delinquent debts under these programs.

Additional information regarding this form, routine uses of information, and our programs and systems, is available on-line at www.ssa.gov or at your local Social Security office.

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 THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. The office is 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, 6401 Annex Building, Baltimore, MD 21235-6401.* ***Send only comments relating to our time estimate to this address, not the completed form.***