

REQUEST FOR WITHDRAWAL OF APPLICATION

Do not write in this space

IMPORTANT NOTICE - This is a request to cancel 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
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IF DIFFERENT, PRINT YOUR NAME <i>(First name, middle initial, last name)</i>	YOUR SOCIAL SECURITY NUMBER
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TYPE OF BENEFIT YOU WANT TO WITHDRAW	DATE OF APPLICATION	IF APPLICABLE, DO YOU WANT TO KEEP MEDICARE BENEFITS? <input type="checkbox"/> Yes <input type="checkbox"/> No
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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a determination of my entitlement has been made, there must be repayment of all benefits paid on the application I want withdrawn, and all other persons whose benefits would be affected must consent to this withdrawal. I further understand that the application withdrawn and all related material will remain a part of the records of the Social Security Administration and that this withdrawal will not affect the proper crediting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 <i>(First name, middle initial, last name)</i> <i>(Write in ink)</i>	Date <i>(Month, day, year)</i>
SIGN HERE	Telephone Number <i>(include area code)</i>

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
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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 <i>(Number and Street, City, State and ZIP Code)</i>	Address <i>(Number and Street, City, State and ZIP Code)</i>

FOR USE OF SOCIAL SECURITY ADMINISTRATION

<input type="checkbox"/> APPROVED	<input type="checkbox"/> NOT APPROVED BECAUSE	<input type="checkbox"/> BENEFITS NOT REPAYED	<input type="checkbox"/> CONSENT(S) NOT OBTAINED	<input type="checkbox"/> OTHER <i>(Attach special determination)</i>
SIGNATURE OF SSA EMPLOYEE		TITLE <input type="checkbox"/> CLAIMS AUTHORIZER <input type="checkbox"/> OTHER <i>(Specify)</i>		DATE

