REQUEST TO WITHDRAW AN APPEALS COUNCIL REQUEST FOR REVIEW

Do not write in this space

IMPORTANT NOTICE – This is a request to withdraw your request for review at the Appeals Council (AC). The AC will consider this request and decide if dismissing your request for review is appropriate. If the AC denies this request, the appeals process will go on as if you had not filed this form. If the AC approves this request, the appeals process will stop. The Administrative Law Judge decision will stay in effect. The dismissal of the request for review is final and cannot be appealed.

1. CLAIMANT NAME

CLAIMANT SSN

2. WAGE EARNER NAME, IF DIFFERENT ***(or, if applicable, name of surviving eligible spouse or other individual eligible to receive benefits due a deceased claimant)***

3. CLAIMANT CLAIM NUMBER, IF DIFFERENT

4. PRINT YOUR NAME ***(First name, middle initial, last name)***

5. DATE APPEALS COUNCIL REVIEW REQUESTED

6. DATE OF ALJ DECISION

I wish to withdraw my request for review. My request is voluntary. I understand the effects of this request. Namely, the Appeals Council may dismiss my request for review. If it does, the Administrative Law Judge decision will stay in effect. This may result in the potential loss of benefits. The Appeals Council's dismissal of this request for review is final and cannot be appealed. My decision affects no other potential parties to my knowledge. I understand that all items relating to my claim will be part of SSA's records.

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

SIGNATURE OF PERSON MAKING REQUEST (OPTIONAL)

☐ Continued on reverse

Signature *(First name, middle initial, last name) (Write in ink)*

Date *(Month, day, year)*

Telephone Number *(Include area code)*

Mailing Address *(Number And Street, Apt. No., PO 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 a mark (X) above. If signed by a mark (X), two witnesses to the signing, who know the person making the request, must sign below. Both witnesses must give their full address.

1. Signature of Witness	2. Signature of Witness
Address (Number and Street, City, State, ZIP Code)	Address (Number and Street, City, State, ZIP Code)

FOR USE OF SOCIAL SECURITY ADMINISTRATION

SSN:

Additional Remarks:

Privacy Act Statement
Collection and Use of Personal Information

Sections 205(a), 1631(d)(1), 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 all or part of the information may prevent us from making an accurate determination regarding your request to withdraw your request for review at the Appeals Council.

We will use the information you provide to decide if dismissing your request is appropriate. We may also share your information for the following purposes, called routine uses:

- To a congressional office in response to an inquiry from that office made at the request of the subject of a record; and
- To a contractor or other Federal agency to assist in the efficient administration of our programs.

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) 60-0004, entitled Working File of the Appeals Council, as published in the Federal Register (FR) on April 29, 2009, at 74 FR 19620 and 60-0009, entitled Hearings and Appeals Case Control System, as published in the FR on October 13, 1982, at 47 FR 45589. 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 10 minutes to read the instructions, gather the facts, and answer the questions. ***Send only comments relating to our time estimate above to***: *SSA*, *6401 Security Blvd, Baltimore, MD 21235-6401.*