

**SOCIAL SECURITY ADMINISTRATION**

OFFICE OF HEARINGS AND APPEALS

Form Approved  
OMB No. 0960-0288

**NOTICE REGARDING SUBSTITUTION OF PARTY UPON DEATH OF CLAIMANT**

**NOTE:** Please read the **PRIVACY ACT/PAPERWORK ACT** statement on reverse and the statements below. Then print, write, or type your response to the statements in the space provided below. If you need additional space, attach a separate page to this form.


NAME OF DECEASED CLAIMANT	CLAIM FOR
WAGE EARNER'S NAME <i>(Leave blank if same as above)</i>	SOCIAL SECURITY NUMBER

I have been informed that the claimant had requested a hearing but died before action on the request was completed. I understand that the deceased claimant's request for hearing will have to be dismissed unless an eligible person is substituted. My relationship to the deceased claimant is:

- Widow/Widower
- Surviving Divorced Spouse
- If you have checked either of the above boxes and have in your care the deceased's child (children) who is (are) under age 16 or disabled, check here
- Child
- Disabled Child
- Parent
- Administrator/Executor of Estate
- Other (Describe) \_\_\_\_\_

Check *either* 1. or 2.

1.  I wish to be made a substitute party and to proceed with the hearing requested by the deceased.  
Check *either* a. or b.
  - a.  I want to come to the hearing in person.
  - b.  I do not want to come to the hearing in person, and I request a decision be made without a hearing.
2.  I do not wish to proceed with the hearing requested by the deceased, and I ask that the request for hearing be dismissed.

SIGNATURE <i>(First Name, Middle Initial, Last Name)</i> SIGN  HERE	DATE <i>(Month, Day, Year)</i>
PRINT OR TYPE FULL NAME	AREA CODE AND TELEPHONE NUMBER

MAILING ADDRESS *(Number and Street Address, P.O. Box or Rural Route)*

CITY, STATE, AND ZIP CODE

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PRIVACY ACT AND PAPERWORK ACT NOTICE: The Social Security Act (sections 205(a), 702, 1631(e)(1)(A) and (B), and 1869(b)(1) and (c), as appropriate, authorizes the collection of information on this form. We need the information to continue processing this claim. You do not have to give it, but if you do not you may not receive benefits under the Social Security Act. We may give out the information on this form without your written consent if we need to get more information to decide if you are eligible for benefits or if a Federal law requires us to do so. Specifically, we may provide information to another Federal, State, or local government agency which is deciding your eligibility for a government benefit or program; to the President or a Congressman inquiring on your behalf; to an independent party who needs statistical information for a research paper or audit report on a Social Security program; or to the Department of Justice to represent the Federal Government in a court suit related to a program administered by the Social Security Administration.

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 any Social Security office.

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.

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