SOCIAL SECURITY ADMINISTRATION/OFFICE OF HEARINGS AN	Form Approved OMB No. 0960-0277	
REQUEST FOR REVIEW OF HEARIN (<u>Do not</u> use this form for objecting to a <u>recom</u> (Take or mail original and all copies to your lock the Veterans Affairs Regional Office in Manila or an	See Privacy Act Notice on Reverse	
1. CLAIMANT	2. WAGE EARNER, IF DIFFERENT	
3. SOCIAL SECURITY CLAIM NUMBER	4. SPOUSE'S NAME AND SOCIAL SECURITY NUMBER (Complete ONLY in Supplemental Security Income Case)	
5. I request that the Appeals Council review the Administrative Law Jud	Ige's action on the above claim becaus	e:
ADDITIONAL If you have additional evidence submit it with this request for review. must request an extension of time in writing now. If you request an exter the evidence or legal argument now. If you neither submit evidence or leg grants, the Appeals Council will take its action based on the evidence of IMPORTANT: Write your Social Security Claim SIGNATURE BLOCKS: You should complete No. 6 and your representative representative is not available to complete this form, you should also prin	. If you need additional time to submit nsion of time, you should explain the re gal argument now nor within any exten record. Number on any letter or material you s re (if any) should complete No. 7. If you	eason(s) you are unable to submit ision of time the Appeals Council end us. u are represented and your
DATE	ATTORNEY	NON-ATTORNEY
6. CLAIMANT'S SIGNATURE	7. REPRESENTATIVE'S SIGNATURE	
PRINT NAME	PRINT NAME	
ADDRESS	ADDRESS	
(CITY, STATE, ZIP CODE)	(CITY, STATE, ZIP CODE)	
TELEPHONE NUMBER FAX NUMBER	TELEPHONE NUMBER F.	AX NUMBER
THE SOCIAL SECURITY ADMINISTRAT	TION STAFF WILL COMPLETE THIS PA	ART
8. Request received for the Social Security Administration on	ate) by:(Pr	int Name)
	116/ (11	int Name)
(Title) (Address)	(Servicing FO	Code) (PC Code)
9. Is the request for review received within 65 days of the ALJ's Decision	on/Dismissal? Yes	No No
10. If no checked: (1) attach claimant's explanation for delay; and (2) attach copy of appointment notice, letter or other	pertinent material or information in the	Social Security Office.
11. Check one: Initial Entitlement	12. Check all claim types that apply:	
Termination or other	 Retirement or survivors Disability-Worker Disability-Widow(er) 	(RSI) (DIWE) (DIWW)
APPEALS COUNCIL OFFICE OF HEARINGS AND APPEALS, SSA 5107 Leesburg Pike FALLS CHURCH, VA 22041 - 3255	 Disability Widow(or) Disability-Child SSI Aged SSI Blind SSI Disability Health Insurance-Part A Health Insurance-Part B Title VIII Only Title VIII/Title XVI Other - Specify: 	(DIWC) (SSIA) (SSIB) (SSID) (HIA) (HIB) (SVB) (SVB/SSI)

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Termination or other		RSI)
APPEALS COUNCIL OFFICE OF HEARINGS AND APPEALS, SSA 5107 Leesburg Pike FALLS CHURCH, VA 22041 - 3255	Disability-Widow(er) () Disability-Child () SSI Aged () SSI Blind () SSI Disability () Health Insurance-Part A () Health Insurance-Part B () Title VIII Only ()	DIWE) DIWW) DIWC) SSIA) SSIB) SSID) HIA) HIB) SVB) SVB/SSI)

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THE SOCIAL SECURITY ADMINISTRAT 8. Request received for the Social Security Administration on	TION STAFF WILL COMPLETE THIS PART	
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(Title) (Address)	(Servicing FO Code	e) (PC Code)
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SOCIAL SECURITY ADMINISTRATION/OFFICE OF HEARINGS AN	ND APPEALS	Form Approved OMB No. 0960-0277
REQUEST FOR REVIEW OF HEARING DECISION/ORDER (Do not use this form for objecting to a recommended ALJ decision.) (Take or mail original and all copies to your local Social Security office, the Veterans Affairs Regional Office in Manila or any U.S. Foreign Service post)		See Privacy Act Notice on Reverse
1. CLAIMANT	2. WAGE EARNER, IF DIFFERENT	
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	Pate) (Print Na	ine)
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	Title VIII/Title XVI (S) Other - Specify:	/B/SSI)