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determination of my entitlement has been made, there must be repayment of all benefits paid on the application I want withdrawn, and all other persons whose benefits would be affected must consent to this withdrawal. I further understand that the application withdrawn and all related material will remain a part of the records of the Social Security Administration and that this withdrawal will not affect the proper crediting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

Please terminate the SS-5 form submitted on my behalf and which resulted in the assignment of the above SSN.

☐ 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:

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 give out are available in Social Security Offices. If you want to learn more about this, contact any 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.** *You may send comments on our time estimate above to: SSA, 1338 Annex Building, Baltimore, MD 21235-6401.* ***Send only comments relating to our time estimate to this address, not the completed form.***