REQUEST FOR REINSTATEMENT (TITLE II)

Wage Earner's Name: _____ **Claim Number:** ____ ___ _____

Claimant's Name: _____

I request reinstatement of my Social Security Disability Benefits. I am disabled and my impairment is the same as (or related to) the impairment which was the basis for my prior entitlement. I am not performing substantial gainful activity (SGA) and my medical condition prevents me from performing SGA.

I understand that I may be able to receive provisional benefits while my request for reinstatement is being decided.

FOR INDIVIDUALS WHO HAVE EXTENDED MEDICARE COVERAGE:

I understand that my Medicare coverage (Part A hospital insurance and Part B medical insurance) could terminate if my request for reinstatement is denied.

I know that anyone who makes or causes to be made a false statement or representation of material fact in this request or for use in determining a right to payment under the Social Security Act commits a crime punishable under Federal law by fine, imprisonment or both. I affirm that all information I have given in this document is true.

_____	___/___/___	(__)____ - _____
Signature	**Date**	**Telephone**

Address: _____

_____

_____