Social Security Administration

EXHIBIT 11

TITLE II

Form Approved
OMB No. 0960-0442

CESSATION OR CONTINUANCE OF DISABILITY OR BLINDNESS DETERMINATION AND TRANSMITTAL

1.A. SOCIAL SECURITY NUMBER: XXX | XX | XXXX | BIC: A

No further monies or other benefits may be paid out under this program unless this report is completed and filed as required by existing public law 93-233.

1.B. TYPE CLAIM: ☒ DIB ☐ FZ ☐ DWB ☐ CDB ☐ ESRD ☐ HIB

1.C. OTHER ENTITLEMENT: ☐ TITLE II ☐ TITLE XVI AS NEEDED

2.A. NAME OF PAYEE (*IF ANY*): If needed

3 WE'S NAME (*IF CDB or DWB CLAIM*):

B. NAME OF DISABLED OR BLIND INDIVIDUAL: XXXX | X | XXXXX

4. DATE OF BIRTH: mm/DD/YY

5. DATE DISABILITY BEGAN: mm/DD/YY

C. ADDRESS: XXXX Xxxxxx Xxxx
XXXXXXXX XX XXXXX

6. DO ADDRESS: XXXX Xxxxx XX
Xxxxxxx XX xxxxx

7. DO CODE: XXX

DDS CODE:

8. AS NEEDED
A. ☐ INITIAL B. ☐ RECON C. ☐ RECON DHU D. ☐ ALJ HEARING E. ☐ APPEALS COUNCIL F. ☐ U.S.DISTRICT COURT G. ☐ REOPENING

9. UPON CONSIDERATION OF ALL FACTS, IT IS DETERMINED: ☒ DISABILITY ☐ IMPAIRMENT SEVERITY (EPE MEDICAL REVIEW ONLY)

		MONTH	DAY	YEAR
X	A. CONTINUES			
	B. CEASED			
	C. PERIOD OF DISABILITY TERMINATED AT THE CLOSE OF THE LAST DAY OF (AS NEEDED)			
	D. EPE BEGIN MONTH			
	E. EPE REINSTATEMENT ALLOWED			
	F. EPE REINSTATEMENT DENIED			
	G. EPE SUSP. AFTER REINSTATEMENT			
	H. EPE BENEFIT TERMINATION MONTH			

		MONTH	DAY	YEAR
	I. 301 CASE			
X	J. BLINDNESS			
X	(1) CONTINUES	0	0	0
	BEGAN			
	(a) DISABLED FOR CASH PURPOSES			
	(b) NOT DISABLED FOR CASH BENEFITS PURPOSES SINCE			
	(2) CEASED			
	(3) CEASED			
	OTHER IMPAIRMENT BEGAN			

10. BASIS FOR DETERMINATION
A. ☐ MEDICAL/MEDICAL VOC. B. ☒ WORK—NO IRWE OR C. ☒ WORK—IRWE INVOLVED D. ☐ OTHER (Explain in item 24.)

11. REASON FOR CESSATION	CODE:	12. REASON FOR CONTINUANCE	CODE: 30
13. ☒ CHECK IF ATTACHING A CONTINUATION SHEET.	14. ☐ CHECK IF VOCATIONAL RULE MET.	CITE RULE	MEDICAL LIST NO. XXXX
15. VOCATIONAL BACKGROUND: XX-XX	16. OCC. YEARS: X	17. EDUC. YEARS: X	18. SPECIAL USE

19. VR ACTION
A. ☐ SC IN B. ☐ SC OUT C. ☐ PREV. REF D. ☐ RE-REF.

20. WHY REVIEW WAS MADE—CODE: 14 or 15

21. PRIMARY DIAGNOSIS	BODY SYSTEM	CODE NO.	22. SECONDARY DIAGNOSIS:	CODE NO.
XXXX	XX	0	XXXX	XXXX

23. DIARY

A. TYPE	B. MONTH	B. YEAR	C. REASON
XXX	XX	XX	X

24. REMARKS: See DI 4105.001.V

MULTIPLE IMPAIRMENTS CONSIDERED
☐ 24A. COMBINED MULTIPLE NONSEVERE--SEVERE
☐ 24B. COMBINED MULTIPLE NONSEVERE–NONSEVERE

25. DISABILITY EXAMINER/CLAIMS REP.	26. DATE	27. PHYSICIAN OR MEDICAL SPEC. SIGNATURE	28. DATE

29. LETTER/PARAGRAPH NUMBER	30. PHYSICIAN OR MEDICAL SPEC. NAME (STAMP PRINT OR TYPE)	30.A SPEC. CODE
SEE NL 00701.425 (SSA-L1013 LETTER)		

31. SSA REPRESENTATIVE	32. SSA CODE	33. DATE
Xxxxxxxx X xxxxxxx	XX	10/05/12

34. LIST NUMBER	A.	B.	C.	D.	E.	F.

35. FOLDER SENT TO: If external location, see DI 41005.001.Z.5, Internal, leave blank

Form **eSSA-833** (5/89)

→ SEE DI 41501.025B FOR DISABILITY RELATED LISTINGS CODES