Social Security Administration

EXHIBIT 13

**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 IF 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. IS 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 |
|---|---|---|---|---|
| | A. CONTINUES | | | |
| | B. CEASED | | | |
| X | C. PERIOD OF DISABILITY TERMINATED AT THE CLOSE OF THE LAST DAY OF | | | |
| | 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 | | | |
| | BEGAN | | | |
| | (a) DISABLED FOR CASH PURPOSES | | | |
| X | (b) NOT DISABLED FOR CASH BENEFITS PURPOSES SINCE | 0 | 0 | 0 |
| | (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 | MEDICAL LIST NO. XXXX | |
| 13. ☒ CHECK IF ATTACHING A CONTINUATION SHEET. | 14. ☐ CHECK IF VOCATIONAL RULE MET. | CITE RULE | |
| 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

If DIB or CDB beneficiary age 55+ show "Beneficiary engaging in comparable SGA."
See DI 41005.V for other remarks

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 |
|---|---|---|
| IF UNDER AGE 55, SEE DI 41005.015C.2.B<br>IF DIB OR CDB AGE 55+ SEE<br>DI 41005.020B.2.B | | |

| 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 LISTINGS CODES