Social Security Administration
Retirement, Survivors, and Disability Insurance
Important Information

FO Address:

Date: _____

BNC#: _____

We are writing to you because we believe you may have recent work activity and we need to know more about this work activity. Please tell us about your work since _____ . If you are applying for disability benefits, the information you provide will help us decide if you can receive benefits. If you are currently receiving disability benefits, the information you provide helps us decide if you can continue to receive benefits.

What You Need To Do

Please complete and return the completed form **within 15 days** to the address shown above. It is important to fill out the form carefully and completely. Remember to sign and date the form. If you do not return this form, we will make our determination based on the evidence we have in our records.

Some Information To Help You Complete This Form

Our records show the following self-employment income for you. This list may not be complete. It may not show your work for this year or last year. You should add any additional work information as you complete the form.

Income Reported for You		
Self-Employment	**Year**	**Yearly Income**

For More Information

Please read the enclosed pamphlet, “Working While Disabled ... How We Can Help.” It will tell you more about why we need to know about your work, and will explain our rules about working. This pamphlet is also available at www.ssa.gov/pubs/EN-05-10095.pdf online.

Suspect Social Security Fraud?

If you suspect Social Security fraud, please visit ***http://oig.ssa.gov/report*** or call the Inspector General's Fraud Hotline at **1-800-269-0271** (TTY **1-866-501-2101**).

If You Have Questions

If you have any questions, or need help completing the form:

- Visit our website at ***www.ssa.gov*** to find general information about Social Security.
- Call us toll-free at **1-800-772-1213**, or call your local office at _____. You may also call your Social Security contact, _____, at _____. We can answer most questions over the phone.
- Write or visit any Social Security office. If you plan to visit an office, you may call ahead to make an appointment. The office that serves your area is located at:

- If you are deaf or hard of hearing, our toll-free TTY number is **1-800-325-0778**.
- If you are outside the United States or its territories:
  - If you are in Canada, visit ***www.ssa.gov/foreign/canada.htm*** to find the office that services your area.
  - Contact your nearest Federal Benefits Unit (FBU). Visit ***www.ssa.gov/foreign/foreign.htm*** for a list of FBUs.
  - Write to the Social Security Administration at:
    P.O. Box 17769
    Baltimore, Maryland 21235-7769
    USA

Please have this letter with you if you call or visit an office. If you write, please include a copy of this letter. It will help us answer your questions.

Social Security Administration

Enclosures:
SSA Pub No. 05-10095
Pre-addressed Envelope

Work Activity Report - Self-Employment

Identification - To Be Completed by SSA

Name of Claimant or Beneficiary	BNC#	☐ Blind ☐ Not Blind

Please use this form to describe your work activity since **(Insert alleged onset date, date of entitlement, or last determination date, as appropriate)**	Date

Information - To Be Completed By Person Applying For Or Receiving Benefits

Please answer each of the questions on this form with as many details as you can. This information will help us decide if you should get or keep getting disability benefits.

If you need more room for your answers, go to the Remarks section at the end of the form.

1. Have you had any self-employment income **since the DATE shown above in the Identification section**? (check one)

☐ **NO.** If you did not work but income was reported for you, **go to Question 2**. For a list of the income that was reported for you, please refer to page 1 in the section entitled **Income Reported for You**.

☐ **YES. Go to Question 3.**

2. If you did not work, but income was reported for you, for each row on page 1 under the section **Income Reported for You**, please provide additional information about the income. If the income reported for you is an error, please explain in the **Remarks** section of the form. When you are finished go to the **Signature** section to complete the form.

Self-Employment Description	Name and Address of Payer	Payment or estimate of value	Date Worked (MM/YYYY-MM/YYYY)
Example: Income after business stopped	ABC Company 123 Any Street Your Town, MD 54321	$100 per day, week, month, or year	01/2000 - 02/2000
		$_____ per_____	
		$_____ per_____	

3. Please tell us about your work **since the DATE shown in the Identification section.**

Type of Self-Employment or Name of Business	Area Code and Telephone Number	Area Code and Fax Number

Mailing address	City	State	ZIP

What is the primary product or service?

Date Work Started (MM/DD/YYYY)	Date Work Ended (if ended) (MM/DD/YYYY)	Still Working ☐	Average Number of Hours Worked per Month

Type of ownership arrangement? (Check one)

☐ Sole Owner ☐ Limited Liability Company (LLC) ☐ Independent Contractor

☐ Corporation ☐ Partnership ☐ Other (Please explain)

☐ Farm Landlord ☐ Farm Tenant

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4. In the space below, show each month you worked in your business, the net earnings, and if you worked 45 hours or more.

Date Worked MM/YYYY	Net Earnings	Worked more than 45 hours per month?	Date Worked MM/YYYY	Net Earnings	Worked more than 45 hours per month?
		☐ Yes ☐ No			☐ Yes ☐ No
		☐ Yes ☐ No			☐ Yes ☐ No
		☐ Yes ☐ No			☐ Yes ☐ No
		☐ Yes ☐ No			☐ Yes ☐ No
		☐ Yes ☐ No			☐ Yes ☐ No
		☐ Yes ☐ No			☐ Yes ☐ No
		☐ Yes ☐ No			☐ Yes ☐ No
		☐ Yes ☐ No			☐ Yes ☐ No
		☐ Yes ☐ No			☐ Yes ☐ No
		☐ Yes ☐ No			☐ Yes ☐ No
		☐ Yes ☐ No			☐ Yes ☐ No
		☐ Yes ☐ No			☐ Yes ☐ No
If you need more room for your answers, **go to the Remarks section.**					

5. Please attach all of your self-employment tax returns (including Schedule C & SE or 1099) **since the DATE shown in the Identification section.**

☐ I have **ENCLOSED** my Tax Returns. **Go to Question 6.**

☐ I **DO NOT have Tax Returns.** For any years that you DO NOT have tax returns, use the chart below to tell us about your total annual gross and net self-employment income.

Year (YYYY)	Gross	Net	Year (YYYY)	Gross	Net
	$	$		$	$
	$	$		$	$

6. Has anyone besides yourself had **management responsibilities** for this business (i.e., a partner, employee, relative, or helper) **since the DATE shown in the Identification section**?

☐ **NO. Go to Question 7.**

☐ **YES.** Complete the questions below.

- How many hours per month (on average) does or did the other person(s) spend on management duties? ________ Hours per month
- How many hours per month (on average) do or did you spend on management duties? ________ Hours per month
- Please tell us what duties you and the other person performed below.

____

____

____

____

____

____

____

____

BNC#: _____

7. Since the DATE shown in the Identification section did you make any changes in your work activity due to your physical and/or mental condition(s)?

☐ **NO. Go to Question 8.**

☐ **YES.** Please describe your changes below (Check all that apply below).

Type of change	Date (MM/DD/YYYY)	Please Explain
☐ Stopped Working		
☐ Reduced my work hours		My hours reduced from _____ per _____ to _____ per _____ because
☐ Changed to lighter or easier work		
☐ Other changes		

8. Has any person or organization **contributed to or paid for** any business expenses or provided any **free help, items, or services** related to your business **since the DATE shown in the Identification section** (For example: rent, supplies, inventory, purchase, repair of equipment, or an employee or helper that works for you for free)?

☐ **NO. Go to Question 9.**

☐ **YES.** Describe the expenses paid or items or services provided, their value of the contribution, and who provided them below.

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9. Do or did you spend any of your own money for items or services **related to your physical and/or mental condition(s)** that you needed in order to work and for which you did not get reimbursed by any other individual or party? (For example: medicines or co-pays, medical devices or procedures, Braille equipment, special telephone or equipment, service animal, attendant care, modifications to a car used for work, or other special transportation.) We may ask you for proof of payment.

☐ **NO. Go to the next section.**

☐ **YES.** Tell us what you paid below. Do not show any expenses that have been or will be paid by an insurance company, other organization, or other person.

Describe Item or Service	Cost	Date Paid (MM/YYYY-MM/YYYY)
Example: Money spent for medicines	$100 per day, week, month, or year	01/2009 - 02/2009
	$_____ per_____	
	$_____ per_____	
	$_____ per_____	
	$_____ per_____	

Remarks

Use this section to add any information you did not have space for in other parts of the form. Please show the number of the question you are answering.

BNC#:

Remarks

Use this section to add any information you did not have space for in other parts of the form. Please show the number of the question you are answering.

Signature

I authorize any employer, agency, or other organization to disclose to the Social Security Administration or the State agency that may determine or review my entitlement to disability benefits, any information about my physical and/or mental condition(s) or my work.

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly gives a false or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime and may be sent to prison, or may face other penalties, or both.

Signature of Claimant, Beneficiary or Representative	Date	Area Code and Telephone Number

Mailing address	City	State	ZIP

If this statement is signed with a mark (e.g. X), two witnesses to the signing who know the person making the statement must sign below, giving their full addresses and telephone numbers.

1. Signature of Witness	Date	Area Code and Telephone Number

Mailing address	City	State	ZIP

2. Signature of Witness	Date	Area Code and Telephone Number

Mailing address	City	State	ZIP

Privacy Act Statement
Collection and Use of Personal Information

Sections 223(d) and 1633 of the Social Security Act, as amended, allow us to collect this information. Furnishing us this information is voluntary. However, failing to provide all or part of the information may prevent an accurate and timely decision on any claim filed.

We will use the information you provide to determine benefits eligibility. We may also share the information for the following purposes, called routine uses:

- To officers and employees of Federal, State or local agencies upon written request, in accordance with the Internal Revenue Code (IRC) (U.S.C. 6103(l)(7)), tax return information (e.g., information with respect to net earnings from self-employment, wages, payments of retirement income which have been disclosed to the Social Security Administration, and business and employment addresses) for purposes of, and to the extent necessary in, determining an individual's eligibility for, or the correct amount of, benefits under certain programs listed in the IRC; and

- To employers, current or former, for correcting or reconstructing earnings records and for Social Security tax purposes.

In addition, we may share this information in accordance with the Privacy Act and other Federal laws. For example, where authorized, we may use and disclose this information in computer matching programs, in which our records are compared with other records to establish or verify a person's eligibility for Federal benefit programs and for repayment of incorrect or delinquent debts under these programs.

A list of additional routine uses is available in our Privacy Act System of Records Notice (SORN) 60-0059, entitled Earnings Recording and Self-Employment Income System, as published in the Federal Register (FR) on January 11, 2006, at 71 FR 1819, and 60-0089, Claims Folders System, as published in the FR on October 31, 2019, at 84 FR 58422. Additional information, and a full listing of all of our SORNs, is available on our website at www.ssa.gov/privacy.

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 (OMB) control number. We estimate that it will take about 30 minutes to read the instructions, gather the facts, and answer the questions. ***Send only comments regarding this burden estimate or any other aspect of this collection, including suggestions for reducing this burden to:*** *SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.*