

**WAIVER OF BENEFIT PAYMENTS**

1. I, \_\_\_\_\_, \_\_\_\_\_  
(Full name of applicant) (Social Security Claim Number)
- request the Social Security Administration (SSA) to discontinue certification of all monthly benefit payments to which I am entitled under the provision of title II of the Social Security Act, as amended, except as provided in paragraph 4 below.
2. I request that no such certification be made by SSA after certification is made for the month of \_\_\_\_\_, 2005
3. I agree to notify the SSA if I expect my earnings to exceed the annual limit (this limit changes each year). If my earnings exceed that annual limit, I agree to file an annual report with SSA.
4. Notwithstanding my entitlement to payments of monthly benefits under title II of the Social Security Act, as amended, I herewith waive, renounce, and disaffirm for myself and my heirs, assigns, and representatives all right, title, and interest to such payments. The waiver, renunciation, and disaffirmation remains in effect until such time as I withdraw the request in writing and ask SSA to resume certification of the payments. I renounce all right to the benefit payments described above except with the month in which SSA received my request for the resumption of certification of payments.

**SIGNATURE OF THE PERSON MAKING THE STATEMENT**SIGNATURE *(First name, middle initial, last name)* *(Write in ink)*DATE *(Month, day, year)***SIGN  
HERE** MAILING ADDRESS *(Number and Street, Apt. No., P.O. Box, or Rural Route)*

CITY

STATE

ZIP CODE