# Instructions for Completing Form SSA-1696

**Keep a copy of this form for your records**

**DO NOT FILE Form SSA-1696 if you do not have a claim, you are not filing a claim with this form, or there is no other case or issue pending decision with us.**

*In this document, "you" means the claimant, beneficiary, auxiliary, or spouse. "We","Us", and "SSA" means the Social Security Administration.*

## General Information About This Form

- You have the right to appoint a qualified representative of your choice to represent you on any claim or asserted right under any of our programs. For more information on who can qualify to be an appointed representative, when your representative's appointment begins or ends, payment of fees to appointed representative(s), and other helpful information, visit our website at www.ssa.gov/representation. To locate your local field office, you can visit our website at www.ssa.gov/locator or call us, toll-free, at 1-800-772-1213.
- You may also choose to be unrepresented. We handle your case in the same manner whether you are represented or unrepresented. You do not need to appoint someone who simply helps you through the process. For example, you do not need to appoint someone who helps you come to our office, reads to you from documents, or interprets for you if you speak another language. You only need to appoint someone if that person will be acting on your behalf or appearing before us on your behalf.
- You and your representative(s) must give us accurate information as quickly as possible. Providing misleading or false information on this form or on your application, or withholding or delaying giving us evidence, could lead to possible criminal charges or administrative sanctions against you and/or your representative.

## Appointing a Representative

If you are using this form to appoint a representative, complete Sections 1, 3, and 4 and enter your Social Security number in the boxes provided at the top of each page after the first page. Your representative should complete Sections 2, 5, 6, and 7 and the Representative ID at the top of each page after the first page. Both you and your representative must sign the form in Section 8. Your representative or someone else can help you complete your sections of the form, but you must sign the form in Section 8. You or your representative must submit the completed form to us before we will recognize your representative. You can electronically upload it, mail, fax, or eFax it to us or file it in-person at your local field office. Do not file this form with your local State Disability Determination Services office. If you are appointing multiple representatives, use separate forms for each representative.

## Section 1 - Reason for Submission and Claimant's Information

Complete all the information, including your Social Security number. If you are filing your claim on someone else's Social Security record, this person is the "number holder", and we need the number holder's information to process your claim. To assist us in processing this form, tell us why you are submitting it by checking all applicable boxes in the "Reason for Submission" section.

## Section 2 - Representative's Information

Your representative must complete the information in this section.

## Section 3 - Claimant's Principal Representative

If you have more than one representative, use this section to name the person you want to be your principal representative. We will make contact and send notices to this person. If you name a new person here, any principal representative you named before will no longer be your principal representative. Your prior principal representative is still your representative unless you revoke the appointment with a separate writing that you sign, date, and file with us.

## Section 4 - Claim Type

In this section, check all types of claims or issues for which you are appointing this representative.

## Section 5 - Representative's Status, Affiliations, and Certifications

- **Part A - Representative's Status, Disqualifications, or Suspensions -** Your representative must complete this section to let us know the representative's status as a professional.

- **Part B - Representative's Affiliation Information -** If your representative is seeking a fee and chooses to designate an affiliate (business, firm, or other organization) for this claim, the representative should complete this section and give us the Employer Identification Number (EIN) of the affiliate entity. If your representative does not want to designate an affiliate entity for this claim or does not qualify for or seek direct payment in this claim, they should check "No EIN".

**Section 5 - Representative's Status, Affiliations, and Certifications - continued**

- **Part C - Assignment of Direct Payment of Authorized Fee to an Entity -** If your representative wants us to pay directly to the entity identified as an affiliate in Part B any representative fee we authorize, the representative must check the entity and the "Assignment" box in this part of the section. We will send the appropriate tax forms to both the entity and the representative. For more information on Forms IRS 1099-MISC or -NEC and employer registration, visit our website at www.ssa.gov/representation.

  If your representative wants to rescind (cancel) their prior assignment and make a new assignment to a different entity, they must provide the information for the new entity in Part B of this section and check the *Assignment* box in this part of the section.

  If your representative wants to rescind (cancel) their prior assignment to an entity and receive direct payment without assigning to a new entity, they must check the *Rescission* box in this part of the section.

- **Part D - Representative's Certifications -** Your representative must also certify the accuracy of all statements in this section.

**Section 6 - Fee Arrangement**

This section reflects you and your representative's agreement on payment of a fee, waiver of direct payment of a fee, or waiver of a fee. Generally, to charge a fee for services, your representative must get our approval. Your representative may waive their right to charge you a fee or tell us that a third-party entity (business, government agency, or organization) will pay the fee. In these situations, the third party must pay out of its own funds the fee and any expenses, and you and any auxiliary beneficiaries (e.g., children or spouse) must be free of any responsibility to pay any fees or expenses.

**Section 7 - Other Claimants**

If auxiliary claimants, such as your children or spouse, have not appointed their own representative(s), list their names and Social Security numbers in this section.

**Section 8 - Signatures**

If you are appointing a new representative, both you and your representative must sign the form in this section.

If you or your representative are submitting this form to update information relating to your existing appointment of this representative:

- You must sign this form if you are updating the information in Section 3.
- Your representative must sign this form if updating the information in Section 5.
- Both you and your representative must sign this form if updating the information in Sections 4, 6, or 7.

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**Privacy Act Statement**
**Collection and Use of Personal Information**

Sections 206 and 1631(d) of the Social Security Act, as amended, allow us to collect your information, which we will use to verify the appointment of your representative and their acceptance of the appointment. Providing this information is voluntary, but not providing all or part of the information may prevent us from assisting you with the request. As law permits, we may use and share the information you submit, including with a congressional office, Federal, State, and local agencies, and others, as outlined in the routine uses within System of Records Notices (SORN) 60-0089, 60-0320, and 60-0325; available at www.ssa.gov/privacy. The information you submit may also be used in computer matching programs to establish or verify eligibility for Federal benefit programs and to recoup debts under these programs.

**Paperwork Reduction Act Statement**

This information collection meets the clearance 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 control number. We estimate that it will take about 30 minutes to read the instructions, gather the facts, and answer the questions. You may send us your comments on our estimated completion time to **SSA, 6401 Security Blvd., Baltimore, MD 21235-6401**. Send only comments relating to our time estimate to this address, not the completed form.

**References**

• 18 U.S.C. §§ 203, 205, and 207; 42 U.S.C. §§ 406 and 1383(d)(2).
• 26 U.S.C. §§ 6041 and 6045(f) and 20 CFR §§ 404.1700 et. seq. and 416.1500 et. seq.

# Claimant's Appointment of a Representative

## Section 1 - Reason for Submission and Claimant's Information

### Reason for Submission

Check the box indicating your reason for submitting this form. If you or your representative are submitting this form to update information provided in your submission, please check the "Update" box and check the box(es) specifying the information you or your representative are updating.

- ☐ **Appoint a new representative**
- ☐ **Update information you previously submitted (Specify below by checking all applicable boxes)**
  - ☐ Claimant's Principal Representative (Section 3)
  - ☐ Claim Type (Section 4)
  - ☐ Representative's Status, Disqualifications or Suspensions (Section 5, Part A)
  - ☐ Representative's Affiliation Information (Section 5, Part B)
  - ☐ Assignment of Direct Payment of Authorized Fee to an Entity (Section 5, Part C)
  - ☐ Fee Arrangement (Section 6)
  - ☐ Other Claimants (Section 7)

### Claimant's Information

| **First Name** | **Initial** | **Last Name** |
|---|---|---|
| | | |

**Claimant's Social Security Number**

| | | | – | | | – | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | – | | | – | | | | |

### Number Holder's Information *(Complete only when applicable)*

My claim is based on another person’s work or earnings (e.g., spouse, parent). This person’s information is different from mine.

**Number Holder's Social Security Number**

| | | | – | | | – | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | – | | | – | | | | |

| **First Name** | **Initial** | **Last Name** |
|---|---|---|
| | | |

## Section 2 - Representative's Information

All representatives must register and receive a Representative Identification (Rep ID). For more information about registration visit us on-line at www.ssa.gov/ar, contact us at 1-800-772-1213 (TTY 1-800-325-0778) or visit your local Social Security office. If your representative wishes to update their registration information, they must do so using Form SSA-1699 *Representative Registration*.

| **First Name** | **Initial** | **Last Name** |
|---|---|---|
| | | |

**Registered Representative Rep ID**

| | | | | | | | | | |
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| | | | | | | | | | |

Claimant's Social Security Number | Representative's Rep ID

## Section 3 - Claimant's Principal Representative *(Complete only when applicable)*

I have appointed more than one representative. The person named below is my principal representative. I ask SSA to make contacts or send notices to this person. Any principal representative I named before is no longer my principal representative but is still one of my representatives unless I have filed a separate writing revoking their appointment.

**Name:**

## Section 4 - Claim Type

I appoint the individual named in Section 2 to act as my representative in connection with my claim(s) or asserted right(s) under Title II (RSDI), Title XVI (SSI), Title XVIII (Medicare Coverage), and Title VIII (SVB) of the Social Security Act, as presently amended, specifically for the issues identified below: (*Check all that apply*)

- ☐ Claim/Appeal for Title II Disability Benefits
- ☐ Claim/Appeal for Title XVI Disability Benefits
- ☐ Claim/Appeal for Title XVI Benefits
- ☐ Claim/Appeal for Retirement Benefits
- ☐ Claim/Appeal for Title XVIII (Medicare), VIII (Special Veteran's Benefits)
- ☐ Continuing Disability Review (CDR)
- ☐ Post-Entitlement Issue (A new issue you raise after eligibility for other benefits)

_____

(E.g., benefit amount, representative payee, suspension, termination, overpayment.)

## Section 5 - Representative's Status, Affiliations, and Certifications

### Part A - Representative's Status, Disqualifications or Suspensions

(Representatives must always keep this information current)

☐ I am an attorney *(SSA rules state that a claimant may appoint an attorney in good standing who has the right to practice law before a court of a State, Territory, District, or island possession of the United States, or before the Supreme Court or a lower Federal court of the United States.)*

☐ I am a non-attorney eligible for direct payment *(SSA rules require that non-attorneys meet certain criteria to qualify for direct payment. See our website at* www.ssa.gov/representation *for the criteria).*

☐ I am a non-attorney not eligible for direct payment.

**I am now or have previously been** *(check all that apply):*

☐ Disbarred or suspended from a court or bar to which I was previously admitted to practice law.

If selected, explain: _____

☐ Disqualified from participating in or appearing before a Federal program or agency.

If selected, explain: _____

☐ Removed from practice or has/had any or all licenses suspended by a professional licensing authority or agency.

If selected, explain: _____

Claimant's Social Security Number

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Representative's Rep ID

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## Part B - Representative's Affiliation Information

If you want to designate an affiliate (business, firm, or other organization) for this claim, provide the entity's name and Employer Identification Number (EIN) here. This number is not your Social Security number (SSN). This number is the entity's tax identification number. **To designate an affiliate entity for this claim, you must have already submitted to us a Form SSA-1699 that identifies this entity as an affiliate.** (*If you do not want to designate an affiliate entity for this claim, or do not qualify for or seek direct payment, mark no EIN.*)

**EIN**

| | | – | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | |

☐ **No EIN**

**Entity's Name** (Enter the full name of the business, firm, or organization with which you want to be affiliated while representing this claim)

## Part C - Assignment of Direct Payment of Authorized Fee to an Entity

*(Complete only when applicable)*

Check the *Assignment* box below if you want to assign direct payment of your fee to the entity you identified above in Part B. If you previously assigned direct payment to another entity, an assignment to a new entity in Part B also constitutes a rescission of the prior assignment. Check only the *Rescission* box below if you want to rescind your prior assignment and receive direct payment with no assignment to an entity.

☐ **Assignment** - I, the representative whose name appears in Section 2 and whose signature appears in Section 8, request any fee authorized to me in this claim be directly paid to the entity identified above in Part B. I understand that the entity to which I assign direct payment of my fee must be registered prior to this assignment. I also understand that I can rescind this assignment only prior to the date SSA notifies the claimant of the first favorable determination or decision. If I previously assigned direct payment to another entity, this assignment also constitutes a rescission of the prior assignment.

☐ **Rescission of prior assignment -** I, the representative whose name appears in Section 2 and whose signature appears in Section 8, rescind my prior assignment of direct payment of my authorized fee.

## Part D - Representative's Certifications

*I accept this appointment and certify the following:*

- I understand and agree that I will comply with the applicable policy and SSA rules on the representation of parties, including the *Rules of conduct and standards of responsibility for representatives* (20 CFR404.1740-404.1799 and 416.1540-416.1599); I will not charge, collect, or retain a fee for representational services that SSA has not approved or that is more than SSA approved unless a regulatory exclusion applies.
- I understand that if I fail to comply with any of applicable policy and SSA rules I may be suspended or disqualified from acting as a representative before SSA.
- I will not disclose any information to any unauthorized party without the claimant's specific written consent.
- I am not currently suspended or disqualified from practicing before the SSA.
- I am not prohibited from representing the claimant as a current or former officer or employee of the United States.
- I accept appointment as the representative for the claimant named in Section 1 of this form in connection with the claims and asserted rights described in Section 4 of this form.
- I agree that a copy of this signed form SSA-1696 will have the same force and effect as the original.
- I declare under penalty of perjury that I have examined all the information on this form and on all accompanying statements or forms, including any information, attestations and certifications provided to SSA in registration, and that they are all currently true and correct to the best of my knowledge.

**I CERTIFY TO ALL OF THE ABOVE** ☐ *(Representative's Initials)*

Claimant's Social Security Number

| | | | - | | | - | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | - | | | - | | | | |

Representative's Rep ID

| | | | | | | | | | |
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## Section 6 - Fee Arrangement *(Representative Only)*

*Check one box below. If the representative is eligible for direct payment and this section is left unchecked, we will assume the representative will seek direct payment of a fee, until we receive a written waiver.*

- ☐ **I will request a fee and direct payment of this fee.** Select this box if you are eligible for direct payment and want us to withhold a portion of the past-due benefits to directly pay the fee we may authorize. *(We must authorize the fee.)*
- ☐ **I will request a fee but not direct payment.** Select this box if you are not eligible for direct payment from the past-due benefits, or if you do not want direct payment. You are responsible for collecting any fee we may authorize on your own. *(We must authorize the fee.)*
- ☐ **I waive the right to receive a fee from the claimant, any auxiliary beneficiaries or any other individual, but a third-party entity will pay my fee.** Select this box if you certify that an entity, or a Federal, state, county, or city government agency will pay the fee and any expenses from its funds. The claimant, auxiliary beneficiaries, or other individuals must not be liable for the fee, directly or indirectly, in whole or in part, or any expenses. *(We do not need to authorize the fee if all regulatory conditions apply.)*
- ☐ **I waive the right to a fee.**

## Section 7 - Other Claimants

*List below any auxiliary claimants, such as a child or spouse of the claimant or number holder, who have not appointed their own representative.*

| Social Security Number | Name |
|---|---|
| ___ - ___ - ____ | |
| ___ - ___ - ____ | |
| ___ - ___ - ____ | |
| ___ - ___ - ____ | |

## Section 8 - Signatures

Both you and your representative must sign this form if you are appointing a new representative. If you or your representative are submitting this form to update information relating to your existing appointment of this representative:

- You must sign this form if you are updating the information in Section 3.
- Your representative must sign this form if updating the information in Section 5.
- Both you and your representative must sign this form if updating the information in Sections 4, 6, or 7.

| **Representative's Signature** | **Date** |
|---|---|
| | |
| **Claimant's Signature** | **Date** |
| | |