EM-97-110 NEW "WAIVER OF OVERPAYMENT" LANGUAGE FOR BENEFIT CONTINUATION ELECTION STATEMENTS -- ACTION

DATE: JULY 30, 1997

TO: ALL RCs/ARCs/ADs/FOs/BOs/TSCs/PSCs/DDSs/FDDS/DQBs/OCRO/ DOCs/ODIO/OIO/ODO/DCO/OTS/OAS/OPSOS/DCS/DCPP/OD/OPBP/ DCFAM/OPLM/OPIR/DCHR/OWA/DHUs/OHACO/OHAROs/OHAHOs/ RPAOs/DDSPROs/HCFACO/HCFAROs

FROM: SSA, OPP, Office of Disability

This teletype provides a new format and replacement language for sections of the model benefit continuation election statements in Program Operations Manual System (POMS) DI 12027.105, Exhibits 1, 2 and 3. The new language below is more explicit about the rights associated with waiver of overpayment.

> I have the right to ask that I not have to pay the money back. If I do ask, and if it is determined by SSA that my appeal was made in good faith and that I need my income and resources for ordinary and necessary living expenses or that other factors apply, I will not have to pay the money back. I also understand that SSA will provide me with more information about waiver of recovery of an overpayment, if I would like it.

Attached in wordperfect 5.0 format are the revised versions of exhibits 1, 2 and 3 that can be overlaid on an SSA-795. You may have to make some slight modifications to fit this overlay on the SSA-795.

When providing an explanation to beneficiaries and/or auxiliaries concerning the waiver of overpayment resulting from benefit continuation, (per DI 12027.005B.7**.), field office staff must include the new language shown above.**

We will revise relevant POMS instructions as soon as possible.

Attachments

DI 12027.105
EXHIBIT 1 - TITLE II BENEFIT CONTINUATION ELECTION STATEMENT

I have been advised of my right to elect to have my disability benefits and Medicare, if applicable, continued to me, pending the outcome of my appeal of the decision that my disability has ceased. I understand that benefits can also be continued to everyone qualified on my Social Security record whom I have specified below.

I understand that if I lose my appeal, I will be asked to pay this money back, including all checks received after my period of disability ended (2 months after the cessation date), through the month such benefits were received if the appeal is not decided in my favor.

I have the right to ask that I not have to pay the money back. If I do ask, and if it is determined by SSA that my appeal was made in good faith and that I need my income and resources for ordinary and necessary living expenses or that other factors apply, I will not have to pay the money back. I also understand that SSA will provide me with more information about waiver of recovery of an overpayment, if I would like it.

I will not be asked to pay back any Medicare benefits I receive while my appeal is being decided.

If I win my appeal, any money I am owed will be paid.

While my appeal is pending and my benefits are being continued, I agree to report promptly to Social Security any changes which may affect my right to receive benefits, such as work activity or any change in the status of dependents receiving benefits on my record.

I understand that if I turn down continued benefits during the specified 10-day period after the initial cessation, I will not have the chance (if the 10-days have passed) to elect continued benefits again until I get the notice of the reconsideration decision on my disability appeal.

I understand that if I do not elect continued benefits when I request reconsideration, but later request a hearing before an administrative law judge (ALJ) and elect continued benefits until an ALJ decision is made, that continued benefits may be paid no earlier than the month of the reconsideration determination or the month of election, whichever is later.

I acknowledge that I understand my responsibilities and that I have been given a copy of this signed statement of choice of benefit continuation options:

Election

_____ I want benefits continued for me and everyone receiving benefits on my Social Security record.

_____ I want only my benefits continued.

_____ I want benefits continued for myself and the following eligible individuals receiving benefits on my Social Security record (specify): _____, _____, _____, _____.

_____ I want benefits continued for everyone receiving benefits on my Social Security record, **except myself.**

_____ I do not want any benefits continued.

_____ I want Medicare coverage for myself and anyone else qualified on my Social Security record, but I do not want any disability benefit payments. I understand that I will be billed directly for the Supplemental Medical Insurance coverage (Medicare Part B), and if payment is not made, the coverage will be terminated.

_____ I want both Part A (hospital insurance) and Part B Medicare coverage continued.

_____ I want only Part A Medicare coverage continued.

DI 12027.105
EXHIBIT 2 - AUXILIARY BENEFIT CONTINUATION ELECTION STATEMENT

I have been advised of my right to have the Social Security benefits I receive because of _____'s disability continued pending the outcome of the appeal regarding the decision that disability has ceased. I have also been advised that my benefits cannot be continued unless _____ requests benefit continuation on my behalf. If benefit continuation on my behalf is requested, my choice of options is indicated below.

I understand that depending upon the outcome of the appeal, I will be asked to pay this money back, including all checks received after _____'s period of disability ended (2 months after the cessation date), through the month such benefits were received if the appeal is not decided in _____'s favor.

I have the right to ask that I not have to pay the money back. If I do ask, and if it is determined by SSA that my appeal was made in good faith and that I need my income and resources for ordinary and necessary living expenses or that other factors apply, I will not have to pay the money back. I also understand that SSA will provide me with more information about waiver of recovery of an overpayment, if I would like it.

I will not be asked to pay back any Medicare benefits I received during the appeal.

If the appeal is won, any money I am owed will be paid.

During this benefit continuation period and while the appeal is

pending, I agree to promptly report to Social Security any changes which may affect my right to receive benefits, such as work activity, marriage, change of address, student status, etc.

I understand that if I turn down continued benefits during the specified 10-day period after the initial cessation, I will not have the chance (if the 10-days have passed) to elect continued benefits again until I get the notice of the reconsideration decision on the disability appeal.

I acknowledge that I understand my responsibilities and that I have been given a copy of this signed statement regarding my choice of benefit continuation options:

ELECTION

_____ I want my benefits continued.

_____ I do not want benefits continued.

_____ I want my Medicare coverage, but I do not want any disability payments. I understand that I will be billed directly for the Supplemental Medical Insurance (Medicare Part B) coverage, and if payment is not made, the coverage will be terminated.

_____ I want both Part A (hospital insurance) and Part B Medicare coverage continued.

_____ I want only Part A Medicare coverage continued.

DI 12027.105
EXHIBIT 3 - TITLE XVI AND CONCURRENT TITLE II/TITLE XVI - BENEFIT CONTINUATION ELECTION STATEMENT

I have been advised of my right to have my SSI disability/blindness benefits and Medicaid coverage (if applicable) continued to me pending the outcome of the appeal regarding the decision that my disability has ceased.

I understand that, if I lose my appeal, I will be asked to pay this money back, including all checks received after my period of disability ended (2 months after the cessation date), through the month such benefits were received if the appeal is not decided in my favor.

I have the right to ask that I not have to pay the money back. If I do ask, and if it is determined by SSA that my appeal was made in good faith and that I need my income and resources for ordinary and necessary living expenses or that other factors apply, I will not have to pay the money back. I also understand

that SSA will provide me with more information about waiver of recovery of an overpayment, if I would like it.

I will not be asked to pay back any Medicaid benefits I received while I was appealing.

If I win my appeal, any money I am owed will be paid.

During this benefit continuation period and while my appeal is pending, I agree to promptly report to Social Security any changes which may affect my right to receive benefits, such as work activity, changes in my income and resources, and living arrangements.

I understand that if I turn down continued benefits during the specified 10-day period after the initial cessation, I will not have the chance (if the 10-days have passed) to elect continued benefits again until I get the notice of reconsideration decision on my disability appeal.

I understand that if I do not elect continued benefits when I request reconsideration, but later request a hearing before an administrative law judge (ALJ) and elect continued benefits until an ALJ decision is made, that continued benefits may be paid no earlier than the month of the reconsideration determination or the month of election, whichever is later.

I acknowledge that I understand my responsibilities and that I have been given a copy of this signed statement regarding my choice of benefit continuation options:

ELECTION

_____ Yes, I want all benefits continued.

_____ I want only these benefits continued (specify): title II _____, title XVI _____.

_____ No, I do not want any benefits continued.