

I. The Parties to This Complaint

A. The Plaintiff(s)

Provide the information below for each plaintiff named in the complaint. Attach additional pages if needed.

Name _____

Street Address _____

City and County _____

State and Zip Code _____

Telephone Number _____

E-mail Address _____

Last Four Digits of Your Social Security Number *(Do not include full number)* _____

B. The Defendant

Provide the information below for the defendant named in the complaint. Attach additional pages if needed.

Defendant *(The current Commissioner of the Social Security Administration)*

Name _____

Street Address _____

City and County _____

State and Zip Code _____

(Regional Office of the Social Security Administration General Counsel.)

Telephone Number _____

E-mail Address *(if known)* _____

II. Basis for Jurisdiction

This is an action seeking court review of a decision of the Commissioner of the Social Security Administration. Jurisdiction for such proceedings can be based on two statutes. If this complaint seeks review of a decision regarding Disability Insurance Benefits under Title II of the Social Security Act, jurisdiction is proper under 42 U.S.C. § 405(g). If this complaint seeks review of a decision regarding Supplemental Security Income under Title XVI of the Social Security Act, jurisdiction is proper under 42 U.S.C. § 1383(c)(3). Please check the type of claim you are filing.

Claim Type	For Clerk's Office Use Only
<input type="checkbox"/> Disability Insurance Benefits Claim (Title II)	COA: 42:0405id NOS: 864
<input type="checkbox"/> Supplemental Security Income Claim (Title XVI)	COA: 42:1383 NOS: 863/864
<input type="checkbox"/> Child Disability Claim	COA: 42:0405wc NOS: 863
<input type="checkbox"/> Widow or Widower Claim	COA: 42:0405ww NOS: 863

An appeal from a decision of the Commissioner must be filed within 60 days of the date on which you received notice that the Commissioner's decision became final. When did you receive notice that the Commissioner's decision was final? *(This is likely the date on which you received notice from the Social Security Appeals Council that your appeal was denied.)*

Please attach a copy of the Commissioner's final decision, and a copy of the notice you received that your appeal was denied from the Social Security Appeals Council.

III. Statement of Claim

Federal courts may overturn decisions by the Commissioner of Social Security only if the decision was not supported by substantial evidence in the record or was based on legal error. Why should this court overturn the Commissioner's decision? *(Check all that apply)*

The Commissioner found the following facts to be true, but these facts are not supported by substantial evidence in the record. *(Explain why the Commissioner's factual findings are not supported by substantial evidence in the record.)*

The Commissioner's decision was based on legal error. *(Identify all legal errors.)*

IV. Relief

State what you want the court to do *(check all that apply)*:

- Issue a summons directing the defendant to appear before the court.
- Order the defendant to submit a certified copy of the transcript and record, including evidence upon which the findings and decision are based.
- Modify the defendant's decision and grant monthly maximum insurance benefits to the plaintiff, retroactive to the date of initial disability.

- In the alternative, remand to the defendant for reconsideration of the evidence.
- Grant any further relief as may be just and proper under the circumstances of this case.

V. Certification and Closing

Under Federal Rule of Civil Procedure 11, by signing below, I certify to the best of my knowledge, information, and belief that this complaint: (1) is not being presented for an improper purpose, such as to harass, cause unnecessary delay, or needlessly increase the cost of litigation; (2) is supported by existing law or by a nonfrivolous argument for extending, modifying, or reversing existing law; (3) the factual contentions have evidentiary support or, if specifically so identified, will likely have evidentiary support after a reasonable opportunity for further investigation or discovery; and (4) the complaint otherwise complies with the requirements of Rule 11.

A. For Parties Without an Attorney

I agree to provide the Clerk’s Office with any changes to my address where case–related papers may be served. I understand that my failure to keep a current address on file with the Clerk’s Office may result in the dismissal of my case.

Date of signing: _____

Signature of Plaintiff _____
Printed Name of Plaintiff _____

B. For Attorneys

Date of signing: _____

Signature of Attorney _____
Printed Name of Attorney _____
Bar Number _____
Name of Law Firm _____
Street Address _____
State and Zip Code _____
Telephone Number _____
E-mail Address _____

CONFIDENTIAL INFORMATION

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF GEORGIA

Plaintiff :
vs. : CIVIL ACTION NO. _____

COMMISSIONER OF SOCIAL SECURITY, :
Defendant :

LOCAL RULE 9.2 SOCIAL SECURITY IDENTIFICATION FORM

- Full Name and complete Social Security Number of Plaintiff, including that of a minor plaintiff not otherwise identified by his or her full name:

Full Name: _____

Social Security Number: _____

- If plaintiff's application for Social Security benefits was filed on another person's wage-record, provide that person's full name and Social Security Number:

Full Name: _____

Social Security Number: _____

Date

Signature