

**UNITED STATES DISTRICT COURT**  
**SOUTHERN DISTRICT OF WEST VIRGINIA**  
**AT**

**Plaintiff,**

**COMPLAINT FOR REVIEW OF THE DECISION  
OF THE  
COMMISSIONER OF SOCIAL SECURITY**

**V.**

**MICHAEL J. ASTRUE,  
Commissioner of Social Security,**

**CIVIL ACTION**

**Defendant.**

Plaintiff's name: \_\_\_\_\_  
*(first, middle, last and other names used, if any)*

Plaintiff's current residence: \_\_\_\_\_  
*(street, apartment no., etc.)*

\_\_\_\_\_  
*(city, county, state and ZIP code)*

Plaintiff's mailing address: \_\_\_\_\_  
*(post office box, etc.)*

\_\_\_\_\_  
*(city, county, state and ZIP code)*

Child's full name *(if Social Security claim is for a child)*: \_\_\_\_\_  
*(first, middle, last and other names used, if any)*

Social Security Number of person claiming benefits: \_\_\_\_\_

Social Security Number of parent or other relevant wage earner: \_\_\_\_\_

Date of birth of person claiming benefits: \_\_\_\_\_

Date of death of wage earner *(if a survivor's claim)*: \_\_\_\_\_

Jurisdiction and venue is based on 42 U.S.C. § 405(g).

Date of Appeals Council's decision: \_\_\_\_\_

The decision of the Commissioner should be *(select those which apply)*:

Reversed

Modified

Remanded

because it is not supported by substantial evidence, and/or because the Commissioner committed other error which is \_\_\_\_\_

Name of attorney *(if any)*: \_\_\_\_\_

Attorney's street address: \_\_\_\_\_

Attorney's telephone number: \_\_\_\_\_

Attorney's fax number: \_\_\_\_\_

Attorney's email address: \_\_\_\_\_

\_\_\_\_\_  
Signature of attorney

If the plaintiff is not represented by an attorney, complete the following:

Plaintiff's telephone number *(if any)*: \_\_\_\_\_

Plaintiff's fax number *(if any)*: \_\_\_\_\_

Plaintiff's e-mail address *(if any)*: \_\_\_\_\_

\_\_\_\_\_  
Signature of plaintiff, if no attorney