Form Approved
OMB No. 0938-0245
Expires: 10/24

REQUEST FOR ENROLLMENT IN SUPPLEMENTARY MEDICAL INSURANCE

WHO CAN USE THIS APPLICATION?

People who wish to enroll in Medicare Part B.

WHEN DO YOU USE THIS APPLICATION?

USE THIS FORM IF:

You wish to enroll in Medicare Part B, but you are NOT entitled to Social Security/Rail Road Retirement Board benefits.

WHAT INFORMATION DO YOU NEED TO COMPLETE THIS APPLICATION?

YOU WILL NEED:

- Your Social Security Number
- Date of Birth
- Your current address and phone number
- Work History

WHAT HAPPENS NEXT?

Send your completed and signed application to your local Social Security office. If you have questions, call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.

HOW DO YOU GET HELP WITH THIS APPLICATION?

- Phone: Call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.
- En español: Llame a SSA gratis al 1-800-772-1213 y oprima el 2 si desea el servicio en español y espere a que le atienda un agente.
- In person: Your local Social Security office. For an office near you check www.ssa.gov.

REMINDERS

- If you sign up for Part B, you must pay premiums for every month you have the coverage.
- If you sign up after your IEP, you may have to pay a late enrollment penalty (LEP) of 10% for each full 12-month period you don't have Part B but were eligible to sign up.

SPECIAL MESSAGE FOR INDIVIDUAL APPLYING FOR MEDICARE

This form is your application for Medicare Part B (Medical Insurance). You can use this form to sign up:

- During your Initial Enrollment Period (IEP) when you're first eligible for Medicare.

INITIAL ENROLLMENT PERIOD

Your IEP is the first chance you have to sign up for Part B. It lasts for 7 months. It begins 3 months before the month you reach 65, and it ends 3 months after you reach 65. If you have Medicare due to disability, your IEP begins 3 months before the 25th month of getting Social Security Disability

- Contributing to your HSA 6 months before applying for Medicare in order to not be penalized by the IRS. For more information about HSA penalties, visit https://www.irs.gov.

REQUEST FOR ENROLLMENT IN SUPPLEMENTARY MEDICAL INSURANCE

1. Print Your Name: (Last Name, First Name, Middle Name)	1a. If your name at birth was different, please enter your name at birth.

2. Sex - Select One	3. Social Security Number:	4. Date of Birth: (MM/DD/YYYY)
☐ Male ☐ Female	_____-___-_____	

4a. State or Country of Birth	4b. Record of Birth

5. Have you ever before enrolled in Medicare Part B?	6. Do you or your spouse receive a mothly annuity under the Federal Civil Service Retirement Act, or other law administered by the office of Personnel Management?
☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No If yes, please provide

6a. If yes, provide the civil service annuity number for you or your spouse.	6b. If you provided your spouse's number, is he or she enrolled in

7. Are you a resident of the United States? This means that you've made your home in the United States. Select One:	8. Are you a US Citizen? Select One:
☐ Yes ☐ No	☐ Yes ☐ No

9. Are you lawfully admitted for permanent residence in the United States? Select One:

☐ Yes ☐ No

10. Write the address for your places of residence in the last 5 years starting with your current address. Use remarks section if you need more space.

	Date Residence Began: MM/DD/YYYY	Date Residence Ended: MM/DD/YYYY
a.		
b.		
c.		

11. Remarks

12. Written Signature	13. Date Signed
	☐☐ / ☐☐ / ☐☐☐☐
14. Address of Witness	14a City, State, Zip
15. Signature of Witness	15a. Date Signed
15b. Address of Witness	

STEP BY STEP INSTRUCTIONS

1. Name: Write your name as you did when you applied for Social Security or Medicare. List last name, first name and middle name in that order. If you don't have a middle name, leave it blank.

1a. If your name at birth was different, please enter your name at birth.

2. Sex: Select One: Male or Female

3. Your Social Security Number: Write your 9 digit social security number.

4. Date of Birth: Write your date of birth (MM/DD/YYYY).

4a. State or Country of Birth: Write the name of the state or foreign country in which you were born (NO abbreviations).

4b. Record of Birth: If a public record of your birth was made before you were age 5 (i.e. birth certificate) you must submit proof. If you do not have a public record of your birth before age 5, submit a religious record of your birth before age 5, if applicable. If neither is known, select unknown.

5. Have you ever before enrolled in Medicare Part B? Select YES, NO, or UNKNOWN

6. Do you or your spouse receive a mothly annuity under the Federal Civil Service Retirement Act, or other law administered by the office of Personnel Management? Select YES or NO. If YES, provide

6a. If yes, provide the civil service annuity number for you or your spouse.

6b. If you provided your spouse's number, is he or she enrolled in

7. Are you a resident of the United States? This means that you've made your home in the United States. Select One: YES or NO

8. Are you a United States Citizen? Select: YES or NO.

9. Are you lawfully admitted for permanent residence in the United States? Select One: YES or NO.

10. Write the address for your places of residence in the last 5 years starting with your current address. Use remarks section if you need more space.

11.Remarks: Write any remarks that you have regarding your application.

12. Written Signature: Sign your name in this section in the same way you would sign it for any other official document. Do not print. If you're unable to sign, you may mark an "X" in this field. In this case, you will need a witness and the witness must complete question 23.

13. Date Signed: Write the date that you signed the application.

14. Mailing Address: Write the house number and street address of your current residence

14a. City, State, Zip code, country: Write the city, state, zipcode and country of your current residence

15. Signature of Witness:In the case that question 21 is signed by an "X" instead of a written signature, a witness signature is needed in question 23 showing that the person who signs the application is the person represented on the application.

15a. Date Signed: If a witness signs this application, the witness must provide the date of the signature.

15b. Address of Witness: If a witness signs this application, provide the witness's address.

PRIVACY ACT STATEMENT: Social Security is authorized to collect your information under sections 1836, 1840, and 1872 of the Social Security Act, as amended (42 U.S.C. 1395o, 1395s, and 1395ii) for your enrollment in Medicare Part B. Social Security and the Centers for Medicare & Medicaid Services (CMS) need your information to determine if you're entitled to Part B. While you don't have to give your information, failure to give all or part of the information requested on this form could delay your application for enrollment. Social Security and CMS will use your information to enroll you in Part B. Your information may be also be used to administer Social Security or CMS programs or other programs that coordinate with Social Security or CMS and in accordance with System of Records Notice (SORN) "HHS/CMS/CBC Enrollment Database", System No. 09-70-0502, 73 Federal Register 10249, February 26th, 2008 and as permitted by the Privacy Act of 1974, to: 1) Determine your rights to Social Security benefits and/or Medicare coverage. 2) Comply with Federal laws requiring Social Security and CMS records (like to the Government Accountability Office and the Veterans Administration) 3) Assist with research and audit activities necessary to protect integrity and improve Social Security and CMS programs (like to the Bureau of the Census and contractors of Social Security and CMS). We may verify your information using computer matches that help administer Social Security and CMS programs in accordance with the Computer Matching and Privacy Protection Act of 1988 (P.L. 100-503).

PRA DISCLOSURE STATEMENT: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0245. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact the Social Security Administration at 1-800-772-1213. TTY users can call 1-800-325-0778.