

APPLICATION FOR ENROLLMENT IN MEDICARE PART B (MEDICAL INSURANCE)

WHO CAN USE THIS APPLICATION?

People with Medicare who have Part A but not Part B

NOTE: If you do **not** have Part A, do **not** complete this form. Contact Social Security if you want to apply for Medicare for the first time.

WHEN DO YOU USE THIS APPLICATION?

Use this form:

- If you're in your **Initial Enrollment Period (IEP)** and live in **Puerto Rico**. You must sign up for Part B using this form.
- If you're in your **IEP** and **refused Part B** or did not sign up when you applied for Medicare, but now want Part B.
- If you want to sign up for Part B during the **General Enrollment Period (GEP)** from January 1 – March 31 each year.
- If you refused Part B during your IEP because you had group health plan (GHP) coverage through your or your spouse's current employment. You may sign up during your 8-month **Special Enrollment Period (SEP)**.
- If you have Medicare due to disability and refused Part B during your IEP because you had group health plan coverage through your, your spouse or family member's current employment. You may sign up during your 8-month **SEP**.

NOTE: Your IEP lasts for 7 months. It begins 3 months before your 65th birthday (or 25th month of disability) and ends 3 months after you reach 65 (or 3 months after the 25th month of disability).

WHAT INFORMATION DO YOU NEED TO COMPLETE THIS APPLICATION?

You will need:

- Your Social Security Claim Number
- Your current address and phone number
- Form CMS-L564 "Request for Employment Information" completed by your employer **if you're signing up in a SEP**.

WHAT HAPPENS NEXT?

Send your completed and signed application to your local Social Security office. If you sign up in a SEP, include the CMS-L564 with your Part B application. 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.

APPLICATION FOR ENROLLMENT IN MEDICARE PART B (MEDICAL INSURANCE)

1. Your Social Security Claim Number	Beneficiary Identification Code (BIC)
<input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>

2. Do you wish to sign up for Medicare Part B (Medical Insurance)? YES

3. Your Name (Last Name, First Name, Middle Name)

4. Mailing Address (Number and Street, P.O. Box, or Route)

5. City	State	Zip Code
<input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

6. Phone Number (including area code)

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7. Written Signature (DO NOT PRINT)	8. Date Signed
SIGN HERE	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

IF THIS APPLICATION HAS BEEN SIGNED BY MARK (X), A WITNESS WHO KNOWS THE APPLICANT MUST SUPPLY THE INFORMATION REQUESTED BELOW.

9. Signature of Witness	10. Date Signed
<input type="text"/>	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

11. Address of Witness

12. Remarks

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 0938-1230. The time required to complete this information is estimated to average 45 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 any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

SPECIAL MESSAGE FOR INDIVIDUAL APPLYING FOR PART B

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

- During your Initial Enrollment Period (IEP) when you're first eligible for Medicare
- During the General Enrollment Period (GEP) from January 1 through March 31 of each year
- If you're eligible for a Special Enrollment Period (SEP), like if you're covered under a group health plan (GHP) based on current employment.

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 benefits, and it ends 3 months after the 25th month of getting Social Security Disability benefits. To have Part B coverage start the month you're 65 (or the 25th month of disability insurance benefits); you must sign up in the first 3 months of your IEP. If you sign up in any of the remaining 4 months, your Part B coverage will start later.

General Enrollment Period

If you don't sign up for Part B during your IEP, you can sign up during the GEP. The GEP runs from January 1 through March 31 of each year. If you sign up during a GEP, your Part B coverage begins July 1 of that year. You may have to pay a late enrollment penalty if you sign up during the GEP. The cost of your Part B premium will go up 10% for each 12-month period that you could have had Part B but didn't sign up. You may have to pay this late enrollment penalty as long as you have Part B coverage.

Special Enrollment Period

If you don't sign up for Part B during your IEP, you can sign up without a late enrollment penalty during a Special Enrollment Period (SEP). If you think that you may be eligible for a SEP, please contact Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778 You can use a SEP when your IEP has ended. The most common SEPs apply to the working aged, disabled, and international volunteers.

Working Aged/Disabled

You have a SEP if you're covered under a group health plan (GHP) based on **current** employment. To use this SEP, you must:

- Be 65 or older and currently employed
- Be the spouse of an employed person, and covered under your spouse's employer GHP based on his/her current employment
- Be under 65 and disabled, and covered under a large group health plan (LGHP) based on your or your spouse's current employment, or the current employment of any family member

You can sign up for Part B anytime while you have a GHP coverage based on current employment or during the 8 months after either the coverage ends or the employment ends, whichever happens first. If you sign up while you have GHP coverage based on current employment, or, during the first full month that you no longer have this coverage, your Part B coverage will begin the first day of the month you sign up. You can also choose to have your coverage begin with any of the following 3 months. If you sign up during any of the remaining 7 months of your SEP, your Part B coverage will begin the month after you sign up.

NOTE: COBRA coverage or a retiree health plan is not considered group health plan coverage based on current employment.

International Volunteers

You have a SEP if you were volunteering outside of the United States for at least 12 months for a tax-exempt organization and had health insurance (through the organization) that provided coverage for the duration of the volunteer service.

Privacy Act Notice: The Social Security Administration (SSA) is authorized to collect the information under sections 1836, 1840 and 1872 of the Social Security Act, as amended (42 U.S.C. 1395o, 1395s, and 1395ii). This information is needed for SSA and the Centers for Medicare & Medicaid Services (CMS) to determine if you are entitled to Supplementary Medical Insurance (Part B). Completing this form is voluntary, but you will not be enrolled in Part B if you do not provide all of the required information. The information you give can be shared for "routine uses" published in the *Federal Register*. Because there are too many to list here, SSA can give you more information about this if you ask. The information you give on this form may be verified by way of computer match (Pub. Law 100-503).

STEP BY STEP INSTRUCTIONS FOR FILLING OUT THIS APPLICATION

- 1. Your Social Security Claim Number:**
Write your social security claim number in each of the boxes. Include any letters following the claim number. These are known as the Beneficiary Identification Code (BIC).
- 2. Do you wish to sign up for Medicare Part B (Medical Insurance)?**
Mark "YES" in this field if you want to sign up for Medicare Part B which provides you with medical insurance under Medicare. You can only sign up using this form if you already have Medicare Part A (Hospital Insurance). If your answer to this question is "no" then you don't need to fill out this application. This application is to sign up to get medical insurance under Medicare.

If you don't have Part A and want to sign up, please contact Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.
- 3. 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.
- 4. Mailing Address:**
Write your full mailing address including the number and street name, P.O. Box, or route in this field.
- 5. City, State, and ZIP code:**
Write the city name, state and ZIP code for the mailing address.
- 6. Phone Number:**
Write your 10-digit phone number, including area code.
- 7. 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 questions 11, 12 and 13.
- 8. Date Signed:**
Write the date that you signed the application.
- 9. Signature of Witness:**
In the case that question 9 is signed by an "X" instead of a written signature, a witness signature is needed in question 11 showing that the person who signs the application is the person represented on the application.
- 10. Date Signed:**
If a witness signs this application, the witness must provide the date of the signature.
- 11. Address of Witness:**
If a witness signs this application, provide the witness's address.
- 12. Remarks:**
Provide any remarks or comments on the form to clarify information about your enrollment application.

IMPORTANT INFORMATION:

Review the scenario below to determine if you need to include additional information or forms with your application.

If you're signing up for Part B using a Special Enrollment Period (SEP) because you were covered under a group health plan based on current employment, in addition to this application, you will also need to have your employer fill out and return the "Request for Employment Information" form ([CMS-L564/CMS-R-297](#)) with your application. The purpose of this form is to provide documentation to Social Security that proves that you have been continuously covered by a group health plan based on current employment, with no more than 8 consecutive months of not having coverage. If your employer went out of business or refuses to complete the form, please contact Social Security about other information you may be able to provide to process your SEP enrollment request.

Send the application (and the "Request for Employment Information," if applicable) to your local Social Security Office. Find your local office at www.ssa.gov.