Form Approved
OMB No. 0938-0251
Expires: 11/30/2027

Application for Medicare Part A (Hospital Insurance)

Who can use this application?

People age 65 and older (and those turning 65 in the next 3 months) who want to apply for Part A. Part A covers hospital care and more.

Note: If you or your spouse works for a railroad or gets railroad benefits, call the Railroad Retirement Board (RRB) at 1-877-772-5772.

When do you use this application?

Use this form:

- If you're eligible for Social Security benefits but only want to get Medicare. You must be at least 64 and 8 months. (You won't pay a premium for Part A.)
- If you're not eligible for Social Security benefits and want to sign up for Part A. You can sign up only during certain times—for more details go to the next page. (You'll pay a premium for Part A.)

Note: Because you're signing up for Part A, you can also sign up for Part B (Medical Insurance) with this form. Part B covers doctors' services and more.

What information do you need to complete this application?

You will need your:

- Social Security Number (SSN)
- Date of birth
- Current address and phone number
- Work history
- **Form CMS-L564 "Medicare Request for Employment Information"** completed by your employer if you're signing up for Part A (and have to pay a premium for it) or Part B during a Special Enrollment Period.

What happens next?

Send your completed and signed application (pages 1–2) to your local Social Security office. If you have questions, call Social Security at 1-800-772-1213. TTY users can call 1-800-325-0778.

How do you get help with this application?

- **Phone:** Call Social Security at 1-800-772-1213. TTY users can call 1-800-325-0778.
- **In person:** Visit your local Social Security office. Find an office near you at **SSA.gov/locator**.
- **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.

Health Savings Account (HSA)

If you're applying after reaching the age of 65, you must stop contributing to your HSA before applying for Medicare to avoid IRS penalties. Premium-free Part A coverage starts up to 6 months back from when you apply (but not earlier than the month you turned 65). Visit **IRS.gov** for more on HSAs.

Reminder

If you have to pay a premium for Part A, or if you also sign up for Part B, you must pay premiums for every month you have the coverage.

You have the right to get Medicare information in an accessible form, like large print, braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit **Medicare.gov/about-us/accessibility-nondiscrimination-notice**, or call 1-800-MEDICARE (1-800-633-4227) for more information. TTY users can call 1-877-486-2048.

When you can apply for Part A (if you have to pay a premium for it) and Part B

Initial Enrollment Period

This is the first chance you have to apply. It lasts for 7 months. It begins 3 months before the month you turn 65, and it ends 3 months after you turn 65. Coverage will begin the month after you sign up.

General Enrollment Period (January 1–March 31 each year)

If you sign up during this time, your coverage will start the month after you sign up. In most cases, you'll have to pay a late enrollment penalty. The penalty is added to your monthly premium, and it goes up the longer you go without coverage.

- **Part A penalty:** If you have to pay a premium for Part A, your premium will go up 10%. You'll pay it for twice the number of years you didn't sign up.
- **Part B penalty:** 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'll pay it for as long as you have Part B coverage.

Special Enrollment Period

- **Working aged/disabled:** You have a Special Enrollment Period if you're covered under a group health plan based on **current** employment. To use this Special Enrollment Period, you must:
  - Be 65 or older and currently employed
  - Be the spouse of an employed person, and covered under your spouse's employer group health plan based on his/her current employment
  - Be under 65 and disabled, and covered under a group health plan based on your own or your spouse's current employment

  You can sign up anytime while you have group health plan 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 group health plan coverage based on current employment, or, during the first full month that you no longer have this coverage, your coverage will begin the first day of the month you sign up. You can also choose to have your coverage begin within any of the following 3 months. If you sign up during any of the remaining 7 months of your Special Enrollment Period, your 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 Special Enrollment Period 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.

If you think you may be eligible for a Special Enrollment Period, contact Social Security at 1-800-772-1213. TTY users can call 1-800-325-0778.

Visit **Medicare.gov** to learn more about when you can sign up and special situations for people under 65 with a disability.

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Application for Medicare Part A (Hospital Insurance)

1. Tell us about yourself

We need this information to find you in our records.

1a. Your Social Security Number (SSN) (or your Medicare Number, if you already have Part B)

SSN: ___ - ___ - ____ Or, Medicare Number: ____ - ___ - ____

1b. Your name (last name, first name, middle name)

1c. Your name as it appears on your birth certificate, if different than item 1b

1d. Sex	1e. Date of birth (mm/dd/yyyy)	1f. State or country of birth (no abbreviations)
☐ Male ☐ Female	__ / __ / ____	

1g. Mailing address (number and street, PO Box, or route)

1h. Address of permanent residence, if different from your mailing address

1i. Phone Number	1j. Email address
(___) ___ – ____	

2. Tell us about your work history

2a. How much were your total earnings last year? If none, write "none."	2b. How much do you expect your total earnings to be this year? If none, write "none."

2c. Did you work in the railroad industry after January 1, 1937? ☐ Yes ☐ No

3. Tell us about your citizenship

3a. Are you a U.S. citizen? (If yes, go to item 4.) ☐ Yes ☐ No

3b. Are you lawfully present in the U.S.? (If no, go to item 4.)	3c. When did you become lawfully present in the U.S.? (mm/dd/yyyy)
☐ Yes ☐ No	__ / __ / ____
3d. Are you currently a resident of the U.S.?	**3e. When did you become a resident of the U.S.? (mm/dd/yyyy)**
☐ Yes ☐ No	__ / __ / ____

3f. Have you resided in the U.S. without a break for the past 5 years? ☐ Yes ☐ No

3g. Enter where you lived for the last 5 years and the dates you lived there. Attach a separate sheet if you need more space.

Address	Started living there (mm/yyyy)	Stopped living there (mm/yyyy)
	__ / ____	__ / ____

3h. Have you been outside the U.S. in the last 5 years? ☐ Yes ☐ No

4. Tell us about your marital status

4a. Are you currently married?	4b. Spouse's name (last name, first name, middle name)	
☐ Yes ☐ No		
4c. Spouse's date of birth (mm/dd/yyyy)	**4d. Spouse's Social Security Number (SSN)**	**4e. Date of marriage (mm/dd/yyyy)**
__ / __ / ____	___ - __ - ____	__ / __ / ____

4f. If you are not married now, did you have a former marriage that lasted 10 or more years OR ended in death? ☐ Yes ☐ No (If no, go to item 5.)

4g. Name of former spouse (last name, first name, middle name)		4h. Former spouse's date of birth (mm/dd/yyyy)
		__ / __ / ____
4i. Spouse's Social Security Number (SSN)	**4j. Date of former marriage (mm/dd/yyyy)**	**4k. Date former marriage ended (mm/dd/yyyy)**
___ - __ - ____	__ / __ / ____	__ / __ / ____
4l. Date of former spouse's death, if deceased (mm/dd/yyyy)	**4m. Do you have another marriage that lasted 10 years or ended in death?** ☐ Yes ☐ No	
__ / __ / ____		

5. Enrollment in premium Part A and Part B

5a. If you have to pay a premium for Part A, do you still want to get Part A? ☐ Yes ☐ No
(If yes, you must also sign up for Part B, and you have to pay monthly premiums.)

5b. Do you want to sign up for Part B? (You pay a monthly premium for Part B.) ☐ Yes ☐ No

6. Tell us about your current or prior health coverage and benefits

We need this information to determine when you can sign up and your premiums.

6a. Do you have Medicaid? (People with Medicaid can get help paying their premiums. If yes, go to item 7.) ☐ Yes ☐ No

6b. Do you currently have (or did you have) coverage through an employer or union group health plan? (If yes, complete item 6d.)
☐ Yes ☐ No

6c. Are you currently (or were you) an international volunteer for a non-profit organization and have or had health coverage provided to you? (If yes, complete item 6d.) ☐ Yes ☐ No

6d. Enter dates of employment (or volunteer work) and health coverage (enter all dates as mm/dd/yyyy). Attach a separate sheet if you need more space.

Dates you (or your spouse) worked for employer that provided health coverage:	Dates of health coverage from employer (or non-profit organization):	Dates you worked as a volunteer outside the U.S.:
Start date: __/__/____	Start date: __/__/____	Start date: __/__/____
End date: __/__/____	End date: __/__/____	End date: __/__/____
☐ Not ended	☐ Not ended	☐ Not ended

6e. Are you (or your spouse) currently getting retirement benefits from the Office of Personnel Management (OPM)? ☐ Yes ☐ No
(If no, go to item 7.)

6f. Your OPM retirement claim number

6g. Your spouse's OPM retirement claim number

6h. Do you want to have your Part B premiums deducted from your spouse's retirement benefits? (See instructions on page 8 before you answer.) ☐ Yes ☐ No

7. Sign your application

7a. If you are completing this application for someone else, what's your name and your relationship to the person applying?

By signing this application, I understand that the information I entered will be used to process my application for Medicare. I understand that if I intentionally provide false information on this form, it is a crime punishable under Federal law by fine, imprisonment, or both. I declare under penalty of perjury that the information I entered is true and correct to the best of my knowledge.

7b. Written signature (do not print)

7c. Date signed __/__/____

If this application has been signed by mark (X), a witness who knows the person applying must also sign this form.

7d. Name of witness (first and last name)

7e. Signature of witness

7f. Date signed __/__/____

I know that anyone who makes or causes to be made a false statement or representation of material fact in an application or for use in determining a right to payment under the Social Security Act commits a crime punishable under Federal law by fine, imprisonment or both. I affirm that all information I have given in this document is true.

Signature of applicant

Date signed __/__/____

Printed name of witness

Signature of witness

Date signed __/__/____

Step-by-step instructions for form CMS-18-F-5

1. Tell us about yourself

a. **Your Social Security Number (SSN) (or your Medicare Number):** Enter your Social Security Number, or if you already have Medicare, you can enter your Medicare Number instead.

b. **Name:** Enter your name. List your last name, first name, and middle name (if you have one) in that order.

c. **Name at birth:** If your name in 1b is different from your name at birth, enter the name you were given at birth. List your last name, first name, and middle name (if you have one) in that order.

d. **Sex:** Select one: male or female

e. **Date of birth:** Enter your date of birth as mm/dd/yyyy.

f. **State or country of birth:** Enter the state or foreign country where you were born. Spell out the location; don't use abbreviations.

g. **Mailing address:** Enter your full mailing address, including the number and street name, city, state, and ZIP code. You can enter a PO Box or route.

h. **Address of permanent residence:** If you live at a different address than where you get mail, enter the full address, including the number and street name, city, state and ZIP code.

i. **Phone number:** Enter your 10-digit phone number, including your area code.

j. **Email address:** Enter the email address where you would like to receive benefits and coverage information.

2. Earnings

a. **How much were your total earnings last year?** Enter the total amount of your W2 wages and net earnings for the prior year. If you don't have any earnings, enter "none."

b. **How much do you think your total earning will be this year?** Enter the total amount you expect your W2 wages and net earnings will be for this year. If you don't have any earnings, enter "none."

c. **Did you work for a railroad after January 1, 1937?** Select one: yes or no. If you select yes, you may have to contact the Railroad Retirement Board at 1-877-772-5772.

3. Citizenship

a. Are you a U.S. citizen? Select one: yes or no. If you select yes, skip items 3b–3g and go to item 4. If you select no, complete items 3b–3g. If you don't qualify to get Part A without paying a premium based on your work earnings or a spouse's work earnings, you may be able to sign up for Part A if you have your green card (lawful permanent residence) and have resided in the U.S. without a break for the last 5 years. You'll have to pay a monthly premium for it.

b. **Are you lawfully present in the U.S.?** Select one: yes or no. To learn more about lawful presence, visit **dhs.gov/get-green-card**. If you select no, skip items 3c–3h and go to item 4.

c. **When did you become lawfully present in the U.S.?** Enter the date you got your lawfully present status. Enter the date as mm/dd/yyyy.

d. **Are you currently a resident of the U.S.?** Select one: yes or no.

e. **When did you become a resident of the U.S.?** Enter the date when both of these first applied: you had lawful presence status and you were living in the U.S. Enter the date as mm/dd/yyyy.

f. Have you resided in the U.S. without a break for the last years? Select one: yes or no.

g. **Enter where you lived for the last 5 years and the dates you lived there:** List the addresses and dates for places you lived for the last 5 years. List the most recent place you lived (or currently live) first. Enter the date you started living at each place, even you moved there more than 5 years ago. Enter dates as mm/dd/yyyy. Attach a separate sheet if you need more space.

h. **Have you been outside the U.S. in the last 5 years?** Select one: yes or no.

4. Marital status

a. **Are you currently married?** Select one: yes or no. If you're divorced or your spouse is deceased, select no, skip items 4a–4e and go to item 4f If you've never been married, skip items 4a–4m and go to item 5.

b. **Name of spouse:** Enter your current spouse's name. List as last name, first name, and middle name (if your spouse has one) in that order.

c. **Spouse's date of birth:** Enter the date of birth for your current spouse. Enter the date as mm/dd/yyyy.

d. **Spouse's Social Security Number (SSN):** Enter the Social Security Number of your current spouse. If you don't know it, enter "unknown."

e. **Date of marriage:** Enter the date you married your current spouse. Enter the date as mm/dd/yyyy.

f. **Former spouse.** Select one: yes or no. If you select no, continue to number 5.

g. **Name of former spouse:** Enter your former spouse's name. If your spouse is deceased or if you're divorced, enter the name here.

h. **Former spouse's date of birth:** Enter the date of birth for your former spouse. Enter the date as mm/dd/yyyy.

i. **Former spouse's Social Security Number (SSN):** Enter the Social Security Number of your former spouse. If you don't know it, enter "unknown."

j. **Date of former marriage:** Enter the date you married your former spouse. Enter the date as mm/dd/yyyy.

k. **Date former marriage ended:** Enter the date your former marriage ended due to divorce. If you're divorced and your former spouse is deceased, also answer item 4L. Enter the date as mm/dd/yyyy.

l. **Date of former spouse's death:** If your spouse is deceased, end your spouse's date of death. Enter the date as mm/dd/yyyy.

m. **Does your spouse (or did your spouse) work for a railroad or get railroad benefits?** Select one: yes or no.

5. Enrollment in premium Part A and Part B:

a. **If you have to pay a premium for Part A, do you still want to get Part A?** Select one: yes or no. If you don't qualify to get Part A without having to pay a premium, you can choose whether you still want to sign up for Part A.
   - If you select yes, you must also sign up for Part B, and you have to pay monthly premiums for both Part A and Part B. Visit Medicare.gov for current premium costs.
   - If you select no, you won't get Part A or Part B.

b. **Do you want to sign up for Part B?** Select one: yes or no. If you're applying for Medicare for the first time, you can choose whether you also want to sign up for Part B (Medical Insurance).
   - If you select yes and you're in one of the enrollment periods listed on page 2 of this form, you'll get Part B. Social Security will tell you when you Part B coverage will start. You'll pay a monthly premium for Part B. Visit Medicare.gov for Part B costs.
   - If you select no and you qualify for Part A without having to pay a premium, you'll just get Part A.
   - If you don't qualify for Part A without having to pay a premium and you want to buy Part A, you must also select yes to this item. In order to buy Part A, you must also get Part B.

6. Current or prior health coverage and benefits

a. **Do you have Medicaid?** Select one: yes or no. Medicaid is a state program that helps pay medical costs for some people with limited income and resources. If you meet certain conditions or have Medicaid, you can get help paying their premiums. Visit Medicare.gov for more on getting help paying costs.

b. **Do you currently have (or did you have) coverage through an employer or union group health plan?** Select one: yes or no. A group health plan is generally a health plan offered by an employer or employee organization that provides health coverage to employees and their families. If you select yes, complete item 6d.

c. **Are you currently (or were you) an international volunteer for a non-profit organization and also have health coverage by that organization?** Select one: yes or no. For more information about international volunteers see the note on page 2. If you select yes, complete item 6d.

d. **Enter dates of employment (or volunteer work) and health coverage:** Only complete this item if you selected yes to item 6b or 6c. You only need to enter any work and health coverage you had since you turned 65.
   - If you selected yes to item 6b, enter information about your (or your spouse's) employer health coverage. You need to list both the dates you (or your spouse) worked for the employer that provided your health coverage in the first column in the chart, and the dates you had health coverage in the second column in the chart.

- If you selected yes to item 6c, enter information about your health coverage while you were volunteering outside the U.S. You need to list both the dates you volunteered for the non-profit organization that provided your health coverage in the third column in the chart, and the dates you had health coverage in the second column in the chart.

Enter both the start and end dates for each item. If it hasn't ended yet, select "not ended." Enter all dates as mm/dd/yyyy. Attach a separate sheet if you need more space.

e. **Are you (or your spouse) currently getting retirement benefits from the Office of Personnel Management (OPM)?** Select one: yes or no. It's also called a civil service annuity. If you select no, skip items 6e-6h, and go to item 7.

f. **Your OPM retirement claim number:** Enter your full OPM retirement claim number. They're also known as CSA and CSF numbers. Include all the letters and numbers for your official OPM claim number. You can find your number on your retirement card, annuity payment statements, welcome letter, or 1099-R tax form from the Office of Personnel Management. Visit OPM.gov for more on how to find your claim number.

g. **Your spouse's OPM retirement claim number:** Enter your spouse's full OPM retirement claim number.

h. **Do you want to have your Part B premiums deducted from your spouse's retirement benefits?** Select one: yes or no. In order to select yes, all of these must apply:
   - You're not getting or applying for Social Security benefits
   - You're not eligible to have the state pay your Medicare premium
   - Your spouse also has Part B and has Part B premiums deducted from their monthly retirement benefit
   - Your spouse provides written consent to have your Part B premiums deducted from their monthly retirement benefit

7. Signing your application

a. **If you are completing this application for someone else, what's your name and your relationship to the person applying?** Enter your full name (first, middle, and last name) and your relationship to the person applying for Part A.

b. **Written signature:** Sign your name 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'll need a witness and the witness must complete items 7a–7c.

c. **Date signed:** Enter the date that you signed the application.

d. **Name of witness:** Enter the full name (first, middle, and last name) of the witness.

e. **Signature of witness:** The witness signs their name in this field. Sign it in the same way you would sign it for any other official document. Do not print. The witness' signature verifies that you are the person applying for Part A and that you signed the application.

f. **Date signed:** Enter the date that the witness signed the application.

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 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)

Paperwork Reduction Act: 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 0938-0251. The time required to complete this information is estimated to average 15 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, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. **Important**: Do not send this form or any items with your personal information (such as claims, payments, medical records, etc.) to the PRA Reports Clearance Office. Any items we get that aren't about how to improve this form or its collection burden (outlined in OMB 0939-0251) will be destroyed. It will not be kept, reviewed, or forwarded to Social Security or any other agency. Go to "What happens next?" on page 1 to send your completed form to Social Security.