Medicare

Medicare Request for Employment Information

Use this form to show proof of group health plan coverage based on current employment so you can enroll in Medicare. You complete Section A of this form, then ask your employer to fill out Section B.

To enroll in Medicare through a Special Enrollment Period, you must have had group health plan coverage through your or your spouse's current employment since the first month you were eligible for Medicare Part B. Your coverage must not have ended more than 8 months ago.

If you qualify for Medicare because of a disability, you must have large group health plan coverage based on your, your spouse's or a family member's current employment.

Submit your form by mail or fax

Mail or fax this completed form together with your Application for Enrollment in Medicare (CMS-40B) to your local Social Security office. Find an office near you at **SSA.gov/locator**.

Get help with this form

- **Phone:** Call Social Security at 1-800-772-1213. TTY users 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:** Visit your local Social Security office for in-person help. Find an office near you at SSA.gov/locator.
- **State Health Insurance Program (SHIP):** Visit **shiphelp.org** to get free, personalized, and unbiased health insurance counseling from your local SHIP.

Get information in another format

You have the right to get Medicare information in an accessible format, 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.

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 0938-0787. 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, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, 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.

Form Approved
OMB No. 0938-0787
Expires: 03/2028

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You complete Section A of this form, then ask your employer to fill out Section B.

Section A: To be completed by person signing up for Medicare Part B (Medical Insurance)

Applicant's name	Applicant's Social Security Number (SSN)
	___ - ___ - ____
Employee's name (if different from applicant)	Employee's SSN (if different)
	___ - ___ - ____

Employer's name

Employer's address

City	State	ZIP code

Section B: To be completed by employer

For Employer Group Health Plans ONLY:

Is (or was) the applicant covered under an employer group health plan? ◯ Yes ◯ No

If yes, give the date the applicant's coverage started (mm/yyyy): ___/____

Did the coverage end? ◯ Yes ◯ No

If yes, give the date the applicant's coverage ended (mm/yyyy): ___/____

When did the employee work for your company?

From (mm/yyyy): ___/____ To (mm/yyyy): ___/____ Still employed? ◯ Yes ◯ No

If you're a large group health plan and the applicant is disabled, list all months your group health plan was primary payer.

From (mm/yyyy): ___/____ To (mm/yyyy): ___/____

For Hours Bank Arrangements ONLY:

Is (or was) the applicant covered under an Hours Bank Arrangement? ◯ Yes ◯ No

If yes, does the applicant have hours left in reserve? ◯ Yes ◯ No

Date reserve hours ended or will be used? (mm/yyyy) ___/____

All Employers:

Signature of company official	**Date signed (mm/dd/yyyy)**
	___/___/____
Title of company official	Phone number
	(___) ___ - ____

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