Medicare

Request for Enrollment in Medicare Part B (Medical Insurance)

Use this form if you already have Medicare Part A and want to sign up for Part B (Medical Insurance). You can use this form to sign up for Part B during these times:

- During your Initial Enrollment Period
- During the General Enrollment Period from January 1–March 31 each year
- If you're eligible for a Special Enrollment Period

If you don't have Part A, don't complete this application. Contact Social Security to apply for Medicare for the first time.

Visit **Medicare.gov/basics/get-started-with-medicare** to learn more about when you can sign up for Medicare, when your coverage can start, and special situations for people under 65 with a disability.

Submit your form by mail or fax

Mail or fax your completed, signed form 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.
- For an office near you visit **SSA.gov/locator**.
- **State Health Insurance Assistance 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.

Form Approved
OMB No. 0938-1230
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Section 1: Basic information

1. Medicare Number
[| | | |] - [| | |] - [| | | |]

2. First name | Middle name | Last name | Suffix

3. Mailing address (number and street, P.O. Box, or route)

City | State [|] | ZIP code [| | | | |]

4. Phone number
([| | |]) [| | |] - [| | | |]

5. Email address

Section 2: Enrollment in Medicare Part B

1. Do you have (or did you have) coverage through an employer or union group health plan since you turned 65? (**If yes,** complete item 3.) ..... ◯ Yes ◯ No

Note: If you sign up for Part B, you must pay premiums for every month you have the coverage.

2. Are you currently (or were you) an international volunteer for a non-profit organization that provided health coverage to you? (**If yes,** complete item 3.)..... ◯ Yes ◯ No

3. Enter dates of employment (or volunteer work) and health coverage (enter dates as mm/yyyy). Attach a separate sheet if you need more space. Have your employer fill out the form CMS-L564 (Request for Employment Information) and return it with your application.

Dates you (or your spouse) worked for an employer that provided health coverage
Start date: [|] / [| | | |] End date: [|] / [| | | |] ☐ Not ended

Dates you worked as a volunteer outside the U.S.
Start date: [|] / [| | | |] End date: [|] / [| | | |] ☐ Not ended

Dates of health coverage from employer (or non-profit organization)
Start date: [|] / [| | | |] End date: [|] / [| | | |] ☐ Not ended

4. Has an employer, health insurance provider, or other entity asked or required you to enroll in Part B? (**If yes,** explain how and why in the space below, and include proof or documentation with this form.)..... ◯ Yes ◯ No

Choose your coverage start date

If you're enrolling in Medicare while you're still covered by a group health plan based on current employment (or during the first full month you're not enrolled in the group health plan), you can choose when your Medicare coverage will start. Choose one:

◯ The first day of the month you enroll

◯ The first day of any of the 3 months **after** you enroll. Write the month and year you want coverage to start: (mm/yyyy)

[| |] / [| | | |]

Section 3: Signature(s)

1. Signature of applicant	2. Date signed (mm/dd/yyyy)
	/ /

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

3. Name of witness (first and last name)	
4. Signature of witness	5. Date signed (mm/dd/yyyy) / /

Submit your form by mail or fax

Mail or fax your completed, signed form to your local Social Security office. Find an office near you at **SSA.gov/locator**.

Privacy Act Statement: Sections 1837, 1838 and 1872 of the Social Security Act, as amended, allow SSA to collect this information. Furnishing this information is voluntary. However, failing to provide all or part of the information may prevent an accurate and timely decision on any claim filed for medical insurance and/or hospital insurance.

We will use the information you provide to determine your eligibility for benefits. We may also share the information for the following purposes, called routine uses: 1) To Federal, State, or local agencies (or agents on their behalf) for administering income maintenance or health maintenance programs (including programs under the Social Security Act). Such disclosure includes, but are not limited to, release of information to: Railroad Retirement Board for administering provision of the Railroad Retirement Act relating to railroad employment; for administering the Railroad Unemployment Insurance Act and for administering provisions of the Social Security Act relating to railroad employment; 2) Department of Veterans Affairs for administering 38 U.S.C. 1312, and upon request, for determining eligibility for, or amount of, veterans benefits or verifying other information with respect thereto pursuant to 38 U.S.C. 5106; 3) State welfare departments for administering sections 205(c)(2)(B)(i)(II) and 402(a)(25) of the Social Security Act requiring information about assigned Social Security numbers for Temporary Assistance for Needy Families (TANF) program purposes and for determining a recipient's eligibility under the TANF program; and 4) State agencies for administering the Medicaid program.

To contractors and other Federal agencies, as necessary, for the purpose of assisting the Social Security Administration (SSA) in the efficient administration of its programs. We will disclose information under the routine use only in situations in which SSA may enter into a contractual or similar agreement with a third party to assist in accomplishing an agency function relating to this system of records.

In addition, we may share this information in accordance with the Privacy Act and other Federal laws. For example, where authorized, we may use and disclose this information in computer matching programs, in which our records are compared with other records to establish or verify a person's eligibility for Federal benefit programs and for repayment of incorrect or delinquent debts under these programs.

A list of additional routine uses is available in our Privacy Act System of Records Notice (SORN) 60-0090, entitled Master Beneficiary Record, as published in the Federal Register (FR) on January 11, 2006, at 71 FR 1826. Additional information, and a full listing of all of our SORNs, is available on our website at **SSA.gov/privacy**.

CMS will maintain records received during eligibility determinations from SSA in a CMS System of Records, the Medicare Beneficiary Database (MBD) SORN 09-70-0536 as published in the Federal Register (FR) on February 14, 2018, at 71 FR 11420. Additional information on CMS SORNs and permissible Routine Uses for disclosure can be located at our Privacy website **HHS.gov/foia/privacy/sorns/index.html**.

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 0938-1230. 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.