Form Approved
OMB No. 0938-1230
Expires: 02/20

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 Medicare 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.

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APPLICATION FOR ENROLLMENT IN MEDICARE PART B (MEDICAL INSURANCE)

1. Your Medicare Number

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

6. Phone Number (including area code)

(☐☐☐) ☐☐☐ – ☐☐☐☐

7. Written Signature (DO NOT PRINT)

SIGN HERE

8. Date Signed

☐☐ / ☐☐ / ☐☐☐☐

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

☐☐ / ☐☐ / ☐☐☐☐

11. Address of Witness

12. Remarks

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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 GHP based on your own or your spouse's current employment

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 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).

STEP BY STEP INSTRUCTIONS FOR FILLING OUT THIS APPLICATION

1. **Your Medicare Number:**
   Write your Medicare number.

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**.

Form Approved
OMB No. 0938-0787

REQUEST FOR EMPLOYMENT INFORMATION

WHAT IS THE PURPOSE OF THIS FORM?

In order to apply for Medicare in a Special Enrollment Period, you must have or had group health plan coverage within the last 8 months through your or your spouse's current employment. People with disabilities must have large group health plan coverage based on your, your spouse's or a family member's current employment.

This form is used for proof of group health care coverage based on current employment. This information is needed to process your Medicare enrollment application.

The employer that provides the group health plan coverage completes the information about your health care coverage and dates of employment.

HOW IS THE FORM COMPLETED?

- Complete the first section of the form so that the employer can find and complete the information about your coverage and the employment of the person through which you have that health coverage.
- The employer fills in the information in the second section and signs at the bottom.

WHAT DO I DO WITH THE FORM?

Fill out Section A and take the form to your employer. Ask your employer to fill out Section B. You need to get the completed form from your employer and include it with your Application for Enrollment in Medicare (CMS-40B). Then you send both together to your local Social Security office. Find your local office here: **www.ssa.gov**.

GET HELP WITH THIS FORM

- **Phone:** Call Social Security at **1-800-772-1213**
- **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**.

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REQUEST FOR EMPLOYMENT INFORMATION

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

1. Employer's Name

2. Date ☐☐ / ☐☐ / ☐☐☐☐

3. Employer's Address

City

State ☐☐

Zip Code ☐☐☐☐☐

4. Applicant's Name

5. Applicant's Social Security Number ☐☐☐ – ☐☐ – ☐☐☐☐

6. Employee's Name

7. Employee's Social Security Number ☐☐☐ – ☐☐ – ☐☐☐☐

SECTION B: To be completed by Employers

For Employer Group Health Plans ONLY:

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

2. If yes, give the date the applicant's coverage began. (mm/yyyy) ☐☐ / ☐☐☐☐

3. Has the coverage ended? ☐ Yes ☐ No

4. If yes, give the date the coverage ended. (mm/yyyy) ☐☐ / ☐☐☐☐

5. When did the employee work for your company?

From: (mm/yyyy) ☐☐ / ☐☐☐☐

To: (mm/yyyy) ☐☐ / ☐☐☐☐

Still Employed: (mm/yyyy) ☐☐ / ☐☐☐☐

6. If you're a large group health plan and the applicant is disabled, please list the timeframe (all months) that your group health plan was primary payer.

From: (mm/yyyy) ☐☐ / ☐☐☐☐

To: (mm/yyyy) ☐☐ / ☐☐☐☐

For Hours Bank Arrangements ONLY:

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

2. If yes, does the applicant have hours remaining in reserve? ☐ Yes ☐ No

3. Date reserve hours ended or will be used? (mm/yyyy) ☐☐ / ☐☐☐☐

All Employers:

Signature of Company Official

Date Signed ☐☐ / ☐☐ / ☐☐☐☐

Title of Company Official

Phone Number (☐☐☐) ☐☐☐ – ☐☐☐☐

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 is 0938-0787. The time required to complete this information collection 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 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, MD 21244-1850.

STEP BY STEP INSTRUCTIONS FOR THIS FORM

SECTION A:
The person applying for Medicare completes all of Section A.

1. **Employer's name:**
   Write the name of your employer.
2. **Date:**
   Write the date that you're filling out the Request for Employment Information form.
3. **Employer's address:**
   Write your employer's address.
4. **Applicant's Name:**
   Write your name here.
5. **Applicant's Social Security Number:**
   Write your Social Security Number here.
6. **Employee's Name:**
   If you get group health plan coverage based on your employment, write your name here. If you get group health plan coverage through another person, like a spouse or family member, write their name.
7. **Employee's Social Security Number:**
   If you get group health plan coverage based on your employment, write your Social Security Number here. If you get group health plan coverage through another person, like a spouse or family member, write their Social Security Number.

Once you complete Section A:
Once Section A is completed, give this form to your employer to complete Section B. Once Section B has been completed by your employer, return this form along with your Part B application to your local Social Security office.

SECTION B:
The employer completes all of Section B.

If you're an employer without an hours bank arrangement, complete the section called "For Employer Group Health Plans ONLY"

1. **Is (or was) the applicant covered under an employer group health plan?**
   Please check yes or no if the applicant was covered under your group health plan offered by your company. The applicant may be the employee or another person related to the employee, such as a spouse or family member with disabilities. If your company doesn't offer a group health plan, please check No. A group health plan is any plan of one or more employers to provide health benefits or medical care (directly or otherwise) to current or former employees, the employer, or their families.
2. **If yes, give the date the coverage began.**
   Write the month and year the date the applicant's coverage began in your group health plan.
3. **Has the coverage ended?**
   Check yes or no if the group health plan coverage for the applicant has ended.
4. **If yes, give the date the coverage ended.**
   Write the month and year the group health plan coverage ended for the applicant.
5. **When did the employee work for your company?**
   Write the start and end dates of the employment for the employee in which the applicant is related. It may be the applicant or another person related to the employee, such as a spouse or family member with disabilities.

   Enter the month and year of the start of the employment in the "From" box.

   Enter the month and year of end of the employment in the "To" box.

   If the employee is still employed, enter the month and year of the current date.

   Current employment is active working status. It is not disability or retirement.
6. **If you're a large group health plan and the applicant is disabled, please list the timeframe (all months) that your group health plan was primary payer.**
   Write the start and end dates that your group health plan was primary payer for the applicant.

If you're an employer with an hours bank arrangement, complete the section called "For Hours Bank Arrangements ONLY"

1. **Is (or was) the applicant covered under an hours bank arrangement?**
   Please check yes or no if the applicant was covered under an hours bank arrangement. If you check no, please also fill out the section for "Employer Group Health Plans ONLY".
2. **If yes, does the applicant have hours remaining in reserve?**

   Please indicate if the applicant currently has health coverage based on the remaining hours in the employee's hours bank account.
3. **Date reserve hours ended or will be used?**
   Please write the month and year for when the remaining hours in the employee's hours bank account expired or will expire.

All employers need to complete the bottom of Section B.

- **Signature of Company Official:**
  An official representative of the company needs to sign this document. Please do not print.
- **Date Signed:**
  Write the date that you sign the form in this field.
- **Title of Company Official:**
  Print the title of the company official who signed the form in this field.
- **Phone Number:**
  Write the phone number of the company official who signed the form in this field. If there are questions regarding the information on this form, a representative from Social Security will contact you.