DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB No. 0938-0425

TOE 810

DO NOT WRITE IN THIS SPACE

REQUEST FOR ENROLLMENT IN SUPPLEMENTARY MEDICAL INSURANCE

PRIVACY ACT NOTICE:

The Social Security Administration (SSA) is authorized to collect the information on this form under sections 1836, 1840, and 1872 of the Social Security Act. Although the information is voluntary, failure to provide all or part of the information requested could cause a delay on your application for enrollment or could be cause for denial of Medicare Part B benefits. Information may be disclosed: 1) to enable a third party or another Federal agency to assist in establishing rights to Social Security benefits and/or hospital or medical insurance coverage; 2) to comply with Federal laws requiring the release of agency records; and 3) to facilitate statistical research and audit activities required by Social Security and CMS programs. In addition, verification of the information may be used in accordance with the computer matching provisions of the Privacy Act of 1974, as amended.

I wish to enroll in Medicare supplementary medical insurance under title XVIII of the Social Security Act, as presently amended. I understand that a premium payment is due for each month of coverage. (See reverse side for information about paying the medical insurance premium.)

1.	a. PRINT your name →	First Name, Middle Initial, Last Name
	b. Enter your name at birth if different from 1(a) →	
	c. Enter your sex (check one) →	❑ Male ❑ Female
	d. Enter your Social Security Number →	__ __ __ / __ __ / __ __ __ __
2.	a. Enter your date of birth (Month, day, year) →	
	b. Enter name of State or foreign country where you were born →	
	If you have not submitted proof of your age complete (c) and (d). c. Was a public record of your birth made before you were age 5? →	❑ Yes ❑ No ❑ Unknown
	d. Was a religious record of your birth made before you were age 5? →	❑ Yes ❑ No ❑ Unknown
3.	Have you ever before enrolled for supplementary medical insurance under Medicare? →	❑ Yes ❑ No ❑ Unknown
4.	a. Do you or your spouse receive a monthly annuity under the Federal Civil Service Retirement Act or other law administered by the Office of Personnel Management? (If "Yes," answer (b). If "No," go on to item 5.) →	❑ Yes ❑ No ❑ Unknown
	b. Enter the Civil Service annuity number here. → (Include the prefix, i.e., "CSA" for annuitant, "CSF" for survivor.) →	Your No. Spouse's No.
	If you entered your spouse's number, is he (she) enrolled for supplementary medical insurance? →	❑ Yes ❑ No ❑ Unknown

If you are entitled to Medicare's hospital insurance omit items 5 and 6.

5.	Are you a resident of the United States? (To reside in a place means to make a home there.) →	❑ Yes ❑ No
6.	a. Are you a citizen of the United States? (If "Yes," omit items b. and c. If "No," answer b. and c. below.) →	❑ Yes ❑ No
	b. Are you lawfully admitted for permanent residence in the United States? →	❑ Yes ❑ No
	c. Enter below the information requested about your place of residence in the last 5 years.	

ADDRESSES AT WHICH YOU RESIDED IN THE LAST 5 YEARS (Begin with the most recent address. Show actual date residence began even if that is prior to the last 5 years.)	DATE RESIDENCE BEGAN			DATE RESIDENCE ENDED		
	Month	Day	Year	Month	Day	Year

(If you need more space, use the "Remarks" space or another sheet of paper)

PAYING YOUR MEDICAL INSURANCE PREMIUM

Once you are enrolled in medical insurance, you must pay a standard monthly premium each month. Your premium may be higher than the standard premium if you enroll in medical insurance more than 3 months after you turn age 65. If you wait more than 3 months after you turn age 65 to enroll in medial insurance, you can do so only during the General Enrollment Period that occurs January through March of each year. Your medical insurance coverage will begin July of the year you enroll. The standard monthly premium will be increased 10% for each full 12-month period you could have had medial insurance but didn't take it.

Your premium will be deducted from any monthly Social Security, Railroad Retirement, or Office of Personnel Management benefit check you receive. If you do not receive any of these benefits, you will be notified how to pay your premiums. You will receive advance notice if there is any change in your premium amount.

Remarks

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

Signature (First Name, Middle Initial, Last Name) Write in Ink SIGN HERE →	Date	Telephone Number

Mailing Address (Number and Street, Apt No., P.O. Box or Rural Route)

City	State	ZIP Code	Name of County (if any) in which you now live

Witnesses are required ONLY if this application has been signed by mark (✘) above. If signed by mark (✘), two witnesses to the signing who know the applicant must sign below, giving their full addresses.

1. Signature of Witness	2. Signature of Witness
Mailing Address (Number and Street, City, State, and Zip)	Mailing Address (Number and Street, City, State, and Zip)