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

Form Approved
OMB No. 0938-0251 (Expires: TBD)

(Do Not Write in this space)

APPLICATION FOR HOSPITAL INSURANCE

(This application form may also be used to enroll in Supplementary Medical Insurance)

I apply for entitlement to Medicare's hospital insurance under part A of title XVIII of the Social Security Act, as presently amended, and for any cash benefits to which I may be entitled under title II of that Act.

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
2.	Enter your Social Security Number →	———/——/———
3.	(a) Enter your date of birth (month, day, year) →	
	(b) Enter name of State or foreign country where you were born →	
	If you have already submitted a public or religious record of your birth made before you were age 5, go on to item 4) →	
	(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
4.	(a) Have you (or has someone on your behalf) ever filed an application for Social Security benefits, a period of disability under Social Security supplemental security income, or hospital or medical insurance under Medicare? →	☐ Yes ☐ No *If "Yes" answer (b) and (c).* *If "No" go on to item 5.*
	(b) Enter name of person on whose Social Security record you filed other application →	
	(c) Enter Social Security Number of person named in (b), (If unknown, so indicate) →	———/——/———
5.	(a) Were you in the active military or naval service (including Reserve or National Guard active duty or active duty for training) after September 7, 1939? →	☐ Yes ☐ No *If "Yes" answer (b) and (c).* *If "No" go on to item 6.*
	(b) Enter dates of service →	*From: (Month, Year)* *To: (Month, Year)*
	(c) Have you ever been (or will you be) eligible for a monthly benefit from a military or civilian Federal agency? (Include Veterans Administration benefits only if you waived military retirement pay) →	☐ Yes ☐ No
6.	Did you work in the railroad industry any time on or after January 1, 1937? →	☐ Yes ☐ No

7. (a) Have you ever engaged in work that was covered under the Social Security system of a country other than the United States? → ☐ Yes ☐ No

(b) If "Yes", list the country(ies). →

8. (a) How much were your total earnings last year? → *If none, write "None"*
Earnings
$

(b) How much do you expect your total earnings to be this year? → *If none, write "None"*
Earnings
$

9. Are you a resident of the United States? → ☐ Yes ☐ No
To reside in a place means to make a home there.

10. (a) Are you a citizen of the United States? → ☐ Yes ☐ No
If "Yes", go on to item 11. If "No", answer (b) and (c) below.

(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:

ADDRESS 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 on the third page or another sheet of paper)

11. Are you currently married? → ☐ Yes ☐ No
If "Yes", give the following information about your current marriage. If "No", go on to item 12.

YOUR CURRENT MARRIAGE

To whom married (Enter your spouse's name)	When (Month, Day, Year)
Spouse's date of birth (or age)	Spouse's Social Security Number *(If none or unknown, so indicate)* ___/___/_____

12. If you had a previous marriage and your spouse died, OR if you had a previous marriage which lasted 10 or more years, give the following information. *If you had no previous marriage(s), enter "NONE."*

YOUR PREVIOUS MARRIAGE

To whom married *(Enter your wife's maiden name or your husband's name)*	When (Month, Day, Year)
Spouse's date of birth (or age)	Spouse's Social Security Number *(If none or unknown, so indicate)* ___/___/_____
If spouse deceased, give date of death →	

(Use "Remarks" space on the page 3 for information about any other marriages.)

13.	Is or was your spouse a railroad worker, railroad retirement pensioner, or a railroad retirement annuitant? →	☐ Yes ☐ No
14.	(a) Were you or your spouse a civilian employee of the Federal Government after June 1960? → *If "Yes," answer (b). If "No," omit (b), (c), and (d).*	☐ Yes ☐ No
	(b) Are you or your spouse now covered under a medical insurance plan provided by the Federal Employees Health Benefits Act of 1959? → *If "Yes," omit (c) and (d). If "No," answer (c).*	☐ Yes ☐ No
	(c) Are you **and** your spouse barred from coverage under the above Act because your Federal employment, or your spouse's was not long enough? → *If "Yes," omit (d) and explain in "Remarks" below. If "No," answer (d).*	☐ Yes ☐ No
	(d) Were either you or your spouse an employee of the Federal Government after February 15,1965? →	☐ Yes ☐ No

Remarks:

15.	If you are found to be otherwise ineligible for hospital insurance under Medicare, do you wish to enroll for hospital insurance on a monthly premium basis (in addition to the monthly premium for supplementary medical insurance)? → *If "Yes," you MUST also sign up for medical insurance.*	☐ Yes ☐ No

INFORMATION ON MEDICAL INSURANCE UNDER MEDICARE

Medical insurance under Medicare helps pay your doctor bills. It also helps pay for a number of other medical items and services not covered under the hospital insurance part of Medicare.

If you sign up for medical insurance, you must pay a premium for each month you have this protection. If you get monthly Social Security, railroad retirement, or civil service benefits, your premium will be deducted from your benefit check, if you get none of these benefits, you will be notified how to pay your premium.

The Federal Government contributes to the cost of your insurance. The amount of your premium and the Government's payment are based on the cost of services covered by medical insurance. The Government also makes additional payments when necessary to meet the full cost of the program. (Currently, the Government pays about two-thirds of the cost of this program.) You will get advance notice if there is any change in your premium amount.

If you have questions or would like a leaflet on medical insurance, call any Social Security office.

SEE OTHER SIDE TO SIGN UP FOR MEDICAL INSURANCE

If you become entitled to hospital insurance as a result of this application, you will be enrolled for medical insurance automatically unless you indicate below that you do not want this protection. If you decline to enroll now, you can get medical insurance protection later only if you sign up for it during specified enrollment periods. Your protection may then be delayed and you may have to pay a higher premium when you decide to sign up.

The date your medical insurance begins and the amount of the premium you must pay depend on the month you file this application with the Social Security Administration. Any Social Security office will be glad to explain the rules regarding enrollment to you.

16.	**DO YOU WISH TO ENROLL FOR SUPPLEMENTARY MEDICAL INSURANCE?** → *If "Yes," answer question 17.* *(Enrollees for premium hospital insurance must simultaneously enroll for medical insurance.)*	☐ Yes ☐ No ☐ Currently Enrolled
17.	Are you or your spouse receiving an annuity under the Federal Civil Service Retirement Act or other law administered by the Office of Personnel Management? →	☐ Yes ☐ No
	If "Yes," enter Civil Service annuity number here. Include the prefix "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 under Social Security? →	☐ Yes ☐ No

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 *(Month, Day, Year)*
Signature (First name, Middle initial, Last name) *Write in Ink* SIGN HERE ➤	Telephone Number(s) at which you may be contacted during the day

Mailing address *(Number and street, Apt. No., P.O. Box, or Rural Route)*

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

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

1. Signature of Witness	2. Signature of Witness
Address *(Number and street, City, State, and ZIP Code)*	Address *(Number and street, City, State, and ZIP Code)*

A REMINDER TO APPLICANTS FOR THE Social Security HOSPITAL INSURANCE

NAME OF PERSON TO CONTACT ABOUT YOUR CLAIM	SSA OFFICE	DATE
TELEPHONE NO.		

RECEIPT FOR YOUR CLAIM

Your application for the hospital insurance has been received and will be processed as quickly as possible.

You should hear from us within days after you have given us all the information we requested. Some claims may take longer if additional information is needed.

In the meantime, if you change your mailing address, you should report the change.

Always give us your claim number when writing or telephoning about your claim.

If you have any questions about your claim, we will be glad to help you.

CLAIMANT	Social Security CLAIM NUMBER

COLLECTION AND USE OF INFORMATION FROM YOUR APPLICATION — PRIVACY ACT NOTICE

PRIVACY ACT NOTICE: The Social Security Administration (SSA) is authorized to collect the information on this form under sections 226 and 1818 of the Social Security Act, as amended (42 U.S.C. 426 and 1395-17) and section 103 of Public Law 89-97. The information on this form is needed to enable Social Security and the Centers for Medicare & Medicaid Services (CMS) to determine if you and your dependents may be entitled to hospital and/or medical insurance coverage and/or monthly benefits. While you do not have to furnish the information requested on this form to Social Security, no benefits or hospital or medical insurance can be provided until an application has been received by a Social Security office. Failure to provide all or part of the information requested could prevent an accurate and timely decision on your claim or your dependent's claim, and could result in the loss of some benefits of hospital or medical insurance.

Although the information you furnish on this form is almost never used for any other purpose than stated above, there is a possibility that for the administration of Social Security or CMS programs or for the administration of programs requiring coordination with SSA or CMS information may be disclosed to another person or to another governmental agency as follows: 1) to enable a third party or an agency to assist Social Security or CMS in establishing rights to Social Security benefits and/or hospital or medical insurance coverage; 2) to comply with Federal laws requiring the release of information from Social Security and CMS records (e.g., to the General Accounting Office and the Veterans Administration); and 3) to facilitate statistical research and audit activities necessary to assure the integrity and improvement of the Social Security and CMS programs (e.g., to the Bureau of the Census and private concerns under contract to Social Security and CMS).

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid 0MB control number. The valid 0MB control number for this information collection is 0938-0251. The time required to complete this information collection is estimated to average 35 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. It 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.