APPLICATION FOR ENROLLMENT IN MEDICARE PART B (MEDICAL INSURANCE) UNDER A SPECIAL ENROLLMENT PERIOD

WHO CAN USE THIS APPLICATION?

People with Medicare who have Part A but not Part B AND qualify for a Special Enrollment Period (SEP)

In order to apply for Medicare in an SEP, you must have or had group health plan (GHP) coverage within the last 8 months through your or your spouse's current employment.

NOTE: If you **do not** have Part A, **do not** complete this form. If you **do not** qualify for an SEP, **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 live in the US and Puerto Rico. You may sign up for Part B using this form.
- If you refused Part B during your Initial Enrollment Period (IEP) because you had GHP coverage through your or your spouse's current employment. You may sign up during your 8-month SEP.

WHAT INFORMATION DO YOU NEED TO COMPLETE THIS APPLICATION?

You will need:

- Your Medicare Number
- Your current address and phone number
- Documentation verifying your GHP coverage through your or your spouse's current employment
- A valid email address

WHAT HAPPENS NEXT?

Complete and then sign the form digitally. To provide your digital signature, you will need to provide an email address. You will receive an email from echosign@echosign.com asking you to confirm your digital signature. Your signature is not complete and your application will not be processed until you complete the instructions in your email. 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.

REMINDERS

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

SPECIAL MESSAGE FOR INDIVIDUALS APPLYING FOR PART B UNDER A SPECIAL ENROLLMENT PERIOD

This form is your application for Medicare Part B (Medical Insurance). You can use this form to sign up for Part B if you're eligible for an SEP and you're covered under a GHP based on current employment.

Do not use this form if you are applying for Medicare Part B under your Initial Enrollment Period (IEP) or during the General Enrollment Period (GEP).

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. **Do not use this application to enroll under your IEP**.

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 for as long as you have Part B. 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. **Do not use this application to enroll under your GEP**.

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 an SEP. If you think you may be eligible for an SEP, use this online application or 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.

WORKING AGED

You have an SEP if you're covered under a GHP based on current employment. To use this SEP, you must:

- Be 65 or older and currently employed
  or
- Be the spouse of an employed person, and covered under your spouse's employer GHP based on his/her 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 (Consolidated Omnibus Budget Reconciliation Act) coverage, retiree health plans, VA coverage, and individual health coverage (like through the Health Insurance Marketplace) aren't considered coverage based on current employment.

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

APPLICATION FOR ENROLLMENT IN MEDICARE PART B (MEDICAL INSURANCE)

SECTION A: Applicant Info

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. Remark (For Example - Desired Coverage Start Date)

SECTION B: Employment Information

1. Employer's Name

2. Employer's Address

City State Zip Code

3. Applicant's Name	4. Applicant's Social Security Number
5. Employee's Name	6. Employee's Social Security 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 xxxx-xxxx. 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.

SECTION C: For Employer Group Health Plans ONLY

Complete this information to the best of your ability.

1. Are or were you covered under an employer group health plan? ☐ Yes ☑ No

2. If yes, provide date coverage began. (mm/yyyy)

3. Has the coverage ended? ☐ Yes ☐ No

4. If yes, provide date coverage ended. (mm/yyyy)

5. When did you or your spouse work for the company?

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

SECTION D: Employment Verification

INSTRUCTIONS

Attach documentation that verifies your group health plan coverage within the last 8 months through your or your spouse's current employment. Please see instructions for acceptable types of verifying documents. Please note that submitting incorrect or incomplete documentation may delay processing of your application and/or cause the application to be rejected.

Only attach PNG, JPG, JPEG, GIF, BMP, PDF, DOC, DOCX, WP, TXT, RTF, HTM, or HTML file types. Attachments are limited to 5 MB and 25 Pages

1. Verifying Documents

Click to attach a file.

Click to attach a file.

2. Signature	3. Date Signed

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STEP BY STEP INSTRUCTIONS FOR FILLING OUT THIS APPLICATION

SECTION A: APPLICANT INFO

1. **Your Medicare Number:**
   Enter 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:**
   Enter 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:**
   Enter your full mailing address including the number and street name, P.O. Box, or route in this field.

5. **City, State, and ZIP code:**
   Enter the city name, state and ZIP code for the mailing address.

6. **Phone Number:**
   Enter your 10-digit phone number, including area code.

7. **Remarks:**
   Provide any remarks or comments on the form to clarify information about your enrollment application.

SECTION B: EMPLOYMENT INFORMATION

The person applying for Medicare completes all of Section B.

1. **Employer's name:** Enter the name of your employer.

2. **Employer's address:** Enter your employer's address.

3. **Applicant's Name:** Enter your name here.

4. **Applicant's Social Security Number:** Enter your Social Security Number here.

5. **Employee's Name:** If you get GHP coverage based on your employment, Enter your name here. If you get GHP coverage through another person, like a spouse or family member, Enter their name.

6. **Employee's Social Security Number:** If you get GHP coverage based on your employment, Enter your Social Security Number here. If you get GHP coverage through another person, like a spouse or family member, enter their Social Security Number.

SECTION C: FOR EMPLOYER GROUP HEALTH PLANS ONLY

1. **Are (or were) you covered under an employer group health plan?** Please check yes or no if you were covered under your group health plan offered by your company. You (the applicant) may be the employee or another person related to the employee, such as a spouse. If the employer 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.** Enter the month and year the group health plan coverage ended for the applicant.

5. **When did the employee work for the company?** Enter the start and end dates of the employment for the employee to which the applicant is related. It may be the applicant or another person related to the employee, such as a spouse. 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.

STEP BY STEP INSTRUCTIONS FOR FILLING OUT THIS APPLICATION

SECTION D: EMPLOYMENT INFORMATION

1. In order to process your application in an SEP, you will need to submit documentation verifying that you have or had GHP coverage within the last 8 months through your or your spouse's current employment.

   Acceptable verifying documentation includes:
   - A letter, fax, or email from your coverage provider (the employer, the GHP). This written notification must be signed by (or come from) the company's or GHP's official, and include: The official's title, the official's phone number and/or other contact information and, the date;
   - Income tax returns that show health insurance premiums paid;
   - W-2s reflecting pre-tax medical contributions;
   - Pay stubs that reflect health insurance premium deductions;
   - Health insurance cards with a policy effective date;
   - Explanations of benefits paid by the GHP or LGHP; and
   - Statements or receipts that reflect payment of health insurance premiums.

2. **Digital Signature:**
   Digitally sign and date the form. To provide your digital signature, you will need to provide an email address. You will receive an email from echosign@echosign.com asking you to confirm your digital signature. Your signature is not complete and your application will not be processed until you complete the instructions in your email. If you have questions, call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.

3. **Date Signed:**
   Enter the date that you signed the application.