Form Approved
OMB No. 0938-0080 (Expires: TBD)

DO NOT WRITE IN THIS SPACE

APPLICATION FOR HOSPITAL INSURANCE BENEFITS FOR INDIVIDUALS WITH END STAGE RENAL DISEASE

I hereby apply for hospital (and medical) insurance benefits under Section 226A of the Social Security Act.

1.	Print your full name *(First Name, Middle Initial, Last Name)*	Social Security Number __ __ __ / __ __ / __ __ __ __
2.	Enter your sex *(check one)* ❑ Male ❑ Female	Maiden Name *(if applicable)*
3.	Enter your date of birth *(Month, day, year)* →	
4.	(a) Are you a U.S. citizen? *(If "Yes," go to 5, if "No," answer (b).)* →	❑ Yes ❑ No
	(b) Are you an alien lawfully present in the U.S.? →	❑ Yes ❑ No
5.	(a) Have you received regularly scheduled dialysis? *(If "Yes," answer (b), if "No," go to 6.)* →	❑ Yes ❑ No
	(b) Enter beginning date and ending date *(if applicable)* of regularly scheduled dialysis *(month, year).* →	Dialysis Began: Ended:
6.	(a) Have you participated *(or do you expect to participate)* in self-dialysis training program? *(If "Yes," answer (b), if "No," go to 7.)* →	❑ Yes ❑ No
	(b) Enter date self-dialysis training began *(or is expected to begin)* *(month, year).* →	
7.	(a) Have you received a kidney transplant? *(If "Yes," answer (b), if "No," go to 8.)* →	❑ Yes ❑ No
	(b) Enter date(s) of transplant(s) *(month, year).* →	
	(c) Were you in a hospital for transplant surgery or for necessary procedures preliminary to transplant before the month you actually received the transplant? *(If "Yes," answer (d), if "No," go to 8.)* →	❑ Yes ❑ No
	(d) Enter date(s) of hospitalization for 7(c) *(month, day, year).*	From: To:

Medicare Part A (Hospital Insurance) helps cover your inpatient care in hospitals. Medicare Part B (medical insurance) pays for most of the costs of physicians' and surgeons' services, and other covered medical services such as OUTPATIENT DIALYSIS TREATMENTS, which are not covered by Medicare Part A. Medicare Part B covers HOME DIALYSIS, including home dialysis equipment and supplies.

Medicare generally cannot pay for any of your hospital or medical bills unless you receive your medical care in the United States (including Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands and American Samoa).

8. **ENROLLMENT IN MEDICARE PART B (MEDICAL INSURANCE)**

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

If you do not enroll in Medicare Part B now, you can do so only during the General Enrollment Period that occurs January through March of each year. Your Medicare Part B coverage will begin July of the year you enroll. The Part B premium will be increased 10% for each full 12-month period you could have had Medicare Part B but didn't take it.

(a) DO YOU WANT TO ENROLL IN MEDICARE PART B (Medical Insurance)? *(If "No," go to 9.)*	→	❑ Yes ❑ No
(b) If your application is processed within 5 months after the first month in which you meet all the requirements for your Medicare entitlement, your coverage will begin with that first month. If your application is processed more than 5 months after your first possible month of entitlement, you may choose one of the following for your first month of coverage. *(Please check one.)*		
The earliest possible month of entitlement, if you are willing and able to pay all premiums for past months of coverage.	→	❑
OR		
The month in which this application is filed, if it is the same as, or later than, your first possible month of entitlement.	→	❑
OR		
The month in which this application is processed.	→	❑

ITEMS 9 THROUGH 17 REQUEST INFORMATION NEEDED TO DETERMINE INSURED STATUS FOR MEDICARE ENTITLEMENT.

9.	(a) Have you (or has someone on your behalf) ever filed an application for Social Security benefits, a period of disability under Social Security, or hospital or medical insurance under Medicare? *(If "Yes," answer (b) and (c), if "No," go to 10.)*	→	❑ Yes ❑ No
	(b) Enter name of person(s) on whose Social Security record(s) you filed other application(s).	→	First name, middle initial, last name
	(c) Enter Social Security number(s) of person(s) named in (b). *(If unknown, so indicate.)*	→	
10.	(a) Have you (or has someone on your behalf) ever filed an application for monthly benefits or hospital or medical insurance under Medicare with the Railroad Retirement Board? *(If "Yes," answer (b) and (c), if "No," go to 11.)*	→	❑ Yes ❑ No
	(b) Enter name of person(s) on whose railroad record you filed other application(s).	→	First name, middle initial, last name
	(c) Enter Railroad number number(s) of person(s) named in (b). *(If unknown, so indicate.)*	→	

IF YOU ARE ALREADY ENTITLED TO A MONTHLY SOCIAL SECURITY BENEFIT OR A MONTHLY RAILROAD ANNUITY, DO NOT COMPLETE ITEMS 11 THROUGH 17.

11.	(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? *(If "Yes," answer (b) , if "No," go to 12.)*	→	❑ Yes ❑ No	
	(b) Enter dates of service *(month, year).*	→	From:	To:
12.	Have you worked in the railroad industry any time on or after January 1, 1937?	→	❑ Yes ❑ No	

13. (a) Enter below the names and addresses of all the persons, companies or government agencies for whom you have worked this year, last year, and the year before last. **IF NONE, WRITE "NONE" BELOW AND GO TO 15.**

NAME AND ADDRESS OF EMPLOYER *(If you had more than one employer, please list them in order beginning with your last (most recent) employer.)*	Work Began		Work Ended *(if still working show "Not Ended")*	
	Month	Year	Month	Year

If you need more space, use "Remarks."

14. May we ask your employers for wage information needed to process your claim? ➔ ❑ Yes ❑ No

15. (a) Were you self-employed this year, last year, or the year before? *(If "Yes," answer (b) , if "No," go to 16.)* ➔ ❑ Yes ❑ No

(b) Check the year or years in which you were self-employed.	In what kind of trade or business were you self-employed?	
❑ This Year		❑ Yes ❑ No
❑ Last Year		❑ Yes ❑ No
❑ Year before Last		❑ Yes ❑ No

IF YOU HAVE BEEN CONTINUALLY EMPLOYED FOR 2 OR MORE YEARS IN THE LAST 3 YEARS, DO NOT COMPLETE ITEMS 16 AND 17.

16. (a) Check your Marital Status *(If single, go to 17.)*

❑ Married ❑ Widowed ❑ Divorced ❑ Single

(b) Enter your wife's maiden name or husband's name	Date of birth	Date of marriage	Date of divorce *(if divorced)*	Date of death *(if deceased)*	Your wife's or husband's Social Security or Railroad Number *(if none or unknown, so indicate.)*

(c) Check whether your marriage was performed by:

❑ Clergyman or authorized public official, or ❑ Other *(Explain in Remarks)*

(d) Were you married before your present marriage? *(If "Yes," give the following information about each of your previous marriages. If you need more space, use "Remarks" section below or attach a separate sheet.)* ➔ ❑ Yes ❑ No

	To Whom Married	When *(month, day, year)*	Where *(enter name of city and state*
Your Previous Marriage			
	To Whom Married	When *(month, day, year)*	Where *(enter name of city and state*

17. Complete the following if you are single:

Mother's Name	Date of Birth	Social Security or Railroad Number
Father's Name	**Date of Birth**	**Social Security or Railroad Number**

Remarks

IMPORTANT: Medicare coverage based on kidney failure will end with either:

a. The last day of the 36th month after the month in which a kidney transplant is received, or
b. The last day of the 12th month after the month in which a regular course of dialysis is discontinued, unless another course of dialysis is initiated or another transplant is received before the last day of coverage.

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 *(daytime)*

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, Street, City, State, ZIP Code)*	Mailing Address *(Number, Street, City, State, ZIP Code)*

PLEASE DETACH THIS PAGE AND KEEP FOR YOUR RECORDS

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Collection and Use of Information from your Application

The Privacy Act of 1974 requires the Social Security Administration to give the following facts to individuals from whom information about themselves is requested:

- the statutory authority for the request,
- whether it is mandatory or voluntary to give the information,
- the principal purpose(s) for which the information is needed,
- the effects of not providing the information, and
- the routine uses which may be made of the information.

These items are explained in the following sections. If you have any questions about your rights under the Privacy Act, you may contact any Social Security office.

I. The Social Security Administration is authorized to collect the information on this form under 205(a), 226(A), and 1872 of the Social Security Act, as amended (42 U.S.C. 405(a), 426, and 1395ii).

II. While it is not mandatory, except in the circumstances explained below, for you to furnish the information on this form to Social Security, hospital insurance entitlement cannot be established unless an application has been received by a Social Security office. Your response is mandatory where the refusal to disclose certain information affecting your entitlement would reflect a fraudulent intent to secure benefits not authorized by the Social Security Act.

III. The information on this form is needed to enable Social Security and the Centers for Medicare & Medicaid Services (CMS) to determine if you are entitled to hospital insurance coverage.

IV. Failure to provide all or part of this information could prevent an accurate and timely decision on your claim, and could result in the loss of some insurance coverage.

V. Although the information you furnish on this form is almost never used for any other purpose than stated in Part III, above, there is a possibility that for the administration of the Social Security or CMS programs or for the administration of programs requiring coordination with Social Security 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 hospital insurance coverage.

2. To comply with Federal laws requiring the release of information from Social Security or CMS records (e.g., to the General Accounting Office and the Veterans' Administration).

3. To facilitate statistical research and audit activities necessary to assure the integrity and improvement of the Social Security or CMS programs (e.g., to the Bureau of the Census and private concerns under contract to Social Security or CMS.)