UNITED STATES OF AMERICA
RAILROAD RETIREMENT BOARD

FORM APPROVED
OMB N0. 3220-0082

SPOUSE/DIVORCED SPOUSE APPLICATION FOR MEDICARE

After completing through 1 Item 10, tab to the receipt on page 6 and' complete the top half.

DO NOT WRITE IN THIS SPACE

OFFICIALLY FILED

MONTH	DAY	YEAR

OFFICE NUMBER

APPROVED

APPLICATION NUMBER

DATE CODED

MONTH	DAY	YEAR

CODED BY

Section 1 Identifying Information

Check the information entered by the Railroad Retirement Board (RRB) for Items 1 through 10 for accuracy.

- ➔ If the information is correct, go to Section 2.
- ➔ If the information is not correct, cross out the incorrect information and enter the correct information above it.
- ➔ If the information is missing, fill it in.

1	RAILROAD EMPLOYEE'S SOCIAL SECURITY NUMBER ➔	
2	EMPLOYEE'S RAILROAD RETIREMENT CLAIM NUMBER ➔	PREFIX: A / NUMBER:
3	EMPLOYEE'S NAME ➔	
4	YOUR NAME ➔	
5 a	MAILING ADDRESS ➔	
	CITY AND STATE ➔	
	ZIP CODE ➔	
5b	FOREIGN ADDRESS ➔	☐ YES ☐ NO
	(IF YES) COUNTRY ➔	
6	YOUR DAYTIME TELEPHONE NUMBER ➔	Area Code / TELEPHONE NUMBER
7	YOUR DATE OF BIRTH ➔	MONTH / DAY / YEAR
8	YOUR SEX ➔	☐ MALE ➔ **Go to Item 10** ☐ FEMALE ➔ **Go to Item 9**

9	YOUR SURNAME AT BIRTH (IF DIFFERENT FROM ITEM 4) →	
10	YOUR SOCIAL SECURITY NUMBER → (If none, enter "TO BE SUBMITTED")	

Section 2 Information about the Employee's Railroad Work and Military Service

11	Has anyone ever filed an application for monthly benefits or Medicare under the Railroad Retirement Act on this account number? →	☐ YES → **Go to Item 19** ☐ NO → **Go to Item 12** ☐ UNKNOWN → **Go to Item 12**
12	Is the employee still working in the railroad industry? →	☐ YES → **Go to Item 14** ☐ NO → **Go to Item 13**
13	Enter the date the employee last worked in the railroad industry. →	MONTH / DAY / YEAR
14	Is the employee age 62 or older in the month you attain age 65? →	☐ YES → **Go to Item 15** ☐ NO → **Go to Item 16**
15	Does the employee have 120 or more months of railroad service? →	☐ YES → **Go to Item 19** ☐ NO → **Go to Item 17**
16	Does the employee have 360 or more months of railroad service? →	☐ YES → **Go to Item 19** ☐ NO → **Go to Item 17**
17	Did the employee have 60 or more months of railroad service after 1995? →	☐ YES → **Go to Item 19** ☐ NO → **Go to Item 18**
18	Was the employee ever in active military service in the U.S. Army, Navy, Air Force, U.S Space Force or Marines? →	☐ YES ☐ NO

Note: *Please read the proofs booklet to find out where to get proof of military service. Creditable military service may be used to determine your eligibility for Medicare.*

Section 3 Applicant's Marital History

19	Enter an "X" in the box which shows your current marital status to the railroad employee. →	☐ Married ☐ Divorced
20	Were you ever married before or since your marriage to the railroad employee? **Note:** *Answer "NO" if you were only remarried to the railroad employee.* →	☐ YES → **Go to Item 21** ☐ NO → **Go to Item 22**

21 Enter the following information about each of your marriages beginning with your most recent one (do not include marriage to the railroad employee).

Marriage Began		Name of Spouse	Marriage Ended		
Date	City and State		How (Check One)	Date	City and State
			☐ Death ☐ Divorce ☐ Annulment		
			☐ Death ☐ Divorce ☐ Annulment		

				☐ Death ☐ Divorce ☐ Annulment		

Section 4 Information about Social Security Entitlement

22	Have you ever filed an application for social security benefits? →	☐ YES → **Go to Item 23** ☐ NO → **Go to Section 5**
23	Did you file for social security benefits based on your own wage record? →	☐ YES → **Go to Section 5** ☐ NO → **Go to Item 24**
24	Name of person on whose record you filed. →	
25	Social security number of person on whose record you filed. →	

Section 5 Request for Enrollment in Medicare Medical Insurance Part B

In addition to applying for Hospital Insurance under Medicare Part A, you may elect to enroll in Medicare Part B. This plan helps pay for physicians' services and certain other medical expenses not covered by the hospital plan (Part A). If you enroll in this medical plan, you will be required to make premium payments.

Initial Enrollment Period (IEP) is the 7-month period when you are first eligible for Medicare. This period begins 3 months before you turn 65, includes the month you turn 65, and ends 3 months after you turn 65. Coverage begins the month after you signs up during your IEP.

You are eligible for a Special Enrollment Period (SEP) if you are age 65 or older, or are under age 65, and disabled, did not elect to be enrolled in Medicare Part B coverage when you became eligible and are covered under an employer group health plan based on your own or your spouse's current employment.

The General Enrollment Period (GEP) is the time period every year from January 1 to March 31 when you can enroll in Medicare Part B for the first time if you missed your Initial Enrollment Period (IEP) and do not qualify for the Part B Special Enrollment Period (SEP).

26	Do you wish to enroll in Medicare Part B? →	☐ YES ☐ NO
27	Type of Medicare Part B enrollment? →	☐ IEP ☐ SEP ☐ GEP

27a. Complete this item only if you are filing in a Special Enrollment Period.

I want my Part B coverage to begin on the first day of:

Month: _____ Year: _____

Section 6	Remarks
28	This section is to be used for the continuation of answers to other items. Be sure to include the item number at the beginning of the answer you wish to continue. You may also use this space to enter any additional information that you feel may be important to include.

Section 7 Certification

29 Will you have a guardian or other representative sign this application on your behalf? →

☐ YES → **Go to Note and Item 29**
☐ NO → **Go to Item 29**

Note: *If answered "YES," the guardian or other representative of the applicant must sign this application. That person must also complete and return Form AA-5, "Application for Substitution of Payee."*

30 I know that if I make a false or fraudulent statement in order to qualify for Medicare from the Railroad Retirement Board (RRB), I am committing a crime which is punishable under Federal law.

I certify that the information I gave to the RRB on this application is true to the best of my knowledge.

I agree to notify the RRB immediately:

- If there is a change in my marital status, or
- If I change my address.

YOUR SIGNATURE
(First Name, Middle Initial, Last Name) →

DATE →

MONTH	DAY	YEAR

31 If this certificate is signed by mark ("X") in Item 29, two witnesses who know the person signing must sign below, giving their full addresses and daytime telephone numbers.

a **Signature of Witness**

Address (Number and Street)

City, State, ZIP Code

Daytime Telephone Number → | Area Code | Telephone Number |

b **Signature of Witness**

Address (Number and Street)

City, State, ZIP Code

Daytime Telephone Number → | Area Code | Telephone Number |

Section 8 How to Return Your Application

Before you return your application, check to make sure that:

- ***EVERY*** QUESTION THAT APPLIES TO YOU HAS BEEN ANSWERED.
- YOU HAVE ENTERED "UNKNOWN" IN ***ANY*** ANSWER SPACE FOR WHICH YOU WERE UNABLE TO ANSWER A QUESTION.
- YOU HAVE SIGNED AND DATED THE APPLICATION.
- YOU HAVE INCLUDED ***ALL*** THE NEEDED PROOFS LISTED IN THE LETTER YOU RECEIVED WITH THIS APPLICATION.

When you received your application, you should also have received a pre-addressed envelope. If you do not have this envelope, you can use any envelope as long as it is addressed to the RRB office shown on page 6 of this application. No matter which envelope you use, you must put the correct postage on the envelope. Be careful to provide enough postage, because your application and the accompanying forms may weigh more than a standard letter. The U.S. Postal Service will not deliver your application unless it has the correct postage.

Make one final check before you seal the envelope to ensure that the following are enclosed:

- NEEDED PROOFS
- THE APPLICATION FORM ITSELF
- ADDITIONAL FORMS YOU WERE ASKED TO COMPLETE

Note *Make no entries on page 6, which is the receipt for your claim. After the RRB receives your application, they will complete the blanks on the receipt and send it back to you. When you receive it you will know that the RRB has received your application and has started the work needed to determine if you are entitled to Medicare. If you do not receive the receipt within two weeks after you filed this application, please contact us so we can find out what is causing the delay.*

Receipt For Your Claim

EMPLOYEE'S NAME

APPLICANT'S NAME	RAILROAD RETIREMENT BOARD CLAIM NUMBER	DATE CLAIM RECEIVED

Your application for Medicare has been received and will be processed as quickly as possible. If you change your address, or if your marital status changes, you or your representative should report the change. Always give us your claim number when writing or calling about your claim. If you have any questions about your claim, we will be glad to help you. If you need to personally visit one of our field offices, please call for an appointment. You will not be refused service if you do not have an appointment, but our staff can serve you better when an appointment is made. RRB office hours can be found on our website at www.rrb.gov.

Always Report These Changes to the RRB

- **Change of Address** – To avoid delay in receipt of RRB correspondence, you should also file a regular change of address notice with your post office.
- **Change of Marital Status** – If you remarry or become divorced or your marriage ends due to the death of your spouse.

How to Report Changes

You can make your reports either by telephone, mail, or in person, whichever you prefer. When a change occurs after you are enrolled for Medicare, you or your representative should report the change at once.

To report any of the above changes, contact:

Telephone Number:

If for some reason you cannot contact that office, you should contact:

U S RAILROAD RETIREMENT BOARD
844 N RUSH ST
CHICAGO IL 60611-1275
(877) 772-5772

ATTESTATION

I understand that anyone who, knowingly and willfully — (1) falsifies, conceals, or covers up by any trick, scheme, or device a material fact; or (2) makes any materially false, fictitious, or fraudulent statements or representations, or makes or uses any materially false writing or document knowing the same to contain any materially false, fictitious, or fraudulent statement or entry, in connection with the delivery of or payment for health care benefits, items, or services, shall be fined or imprisoned not more than 5 years, or both.

Signature (Do **not** print)	Date Signed							
	Month		Day		Year			

Important Notices

Paperwork Reduction Act and Privacy Act Notices

This notice is given under the Paperwork Reduction Act of 1995 and the Privacy Act of 1974. The Privacy Act requires that the Railroad Retirement Board (RRB) tell you the following whenever we ask you for information.

1) The law which allows us to ask for the information;

2) whether that law requires you to give us that information and what, if anything, might happen to you if you do not give it to us;

3) the reason why the information is requested; and

4) the persons, organizations, and agencies to which we may release the information without your permission.

The RRB is authorized to collect the information on this form under sections 7(b) and 7(d) of the Railroad Retirement Act and sections 226, 1836 and 1840 of the Social Security Act, as amended. The information on this form is needed to enable the RRB to determine your eligibility to monthly benefits and entitlement to hospital and/or medical insurance coverage. While you do not have to furnish the information requested on this form, no hospital or medical insurance can be provided until an application has been received. Failure to provide all or part of the information requested could prevent an accurate and timely decision on your claim and could result in the loss 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 the Railroad Retirement, Social Security, and the Centers for Medicare & Medicaid Services programs, information may be disclosed to another person or to another government agency as follows:

1) Beneficiary identification, enrollment status and premium deductions information may be released to the Social Security Administration and the Centers for Medicare & Medicaid Services to correlate action with the administration of Title ll and Title XVIII (MEDICARE) of the Social Security Act.

2) Beneficiary identification may be disclosed to third party contacts to determine if incapacity of the beneficiary or potential beneficiary to understand or use benefits exists, and to determine the suitability of a proposed representative payee.

3) Jurisdictional clearance, premium rate, coverage election, paid-thru date, and amounts of payments in arrears may be released to the Social Security Administration and the Centers for Medicare & Medicaid Services to assist in administering Title XVIII of the Social Security Act.

4) The last address information may be disclosed to the Department of Health and Human Services in conjunction with the Parent Locator Service.

5) Beneficiary identification, entitlement data and rate information may be referred to the Department of State and embassy officials to aid in the development of applications, supporting evidence and the continued eligibility of beneficiaries and potential beneficiaries living abroad.

6) Records may be released to the Government Accountability Office for auditing purposes and for collection of debts arising from overpayments under Title XVIII of the Social Security Act, as amended.

7) Disclosure may be made to a congressional office from the record of an individual in response to an inquiry from the congressional office made at the request of that individual.

8) Pursuant to a request from an employer covered by the Railroad Retirement Act or the Railroad Unemployment Insurance Act, information regarding the RRB's determination of Medicare entitlement, entitlement data and present address may be released to the requesting employer for the purposes of determining entitlement to and rates of supplemental benefits payable under private employer welfare benefit plans.

We estimate this form takes an average of 8 minutes per response to complete, including the time for reviewing the instructions, obtaining the data, and reviewing the completed form. If you wish, send comments regarding the accuracy of our estimate, or any other aspect of this form, including suggestions for reducing completion time, to: Railroad Retirement Board, ATTN: Bureau of Information Services/Policy & Compliance, 844 N. Rush St., Chicago, IL 60611-1275.

Computer Matching and Privacy Protection Act Notice

The Computer Matching and Privacy Protection Act of 1988 requires the Railroad Retirement Board (RRB) to advise you that information you have provided may be used, without your consent, in automated matching programs. These matching programs are a computer comparison of RRB records with records kept by other Federal, state, or local governmental agencies. Information from these matching programs can be used to establish or verify a person's eligibility for Federally funded or administered benefit programs and for repayment of payments or delinquent debts under these programs.