Application for Medicare Part B Special Enrollment Period (SEP) Exceptional Conditions

1. Railroad Retirement Board (RRB) Claim Number

2. Beneficiary's Own Social Security Number

3a. Name and Address	3b. If this is a change of address, check box ☐
,	3c. Daytime Telephone Number (____) _____

4. Do you want to enroll in Medical Insurance (Part B) under Medicare?

☐ Yes ☐ No

Based on the descriptions below, please select the SEP that best fits your situation. If none apply, please contact the RRB to see if there are other options available.

☐ **SEP for Individuals Impacted by an Emergency or Natural Disaster**

Dates of the declared emergency (The declaration must be on or after January 1, 2023):

Start Date: __/____ Ending Date: __/____

Optional Description of Emergency (e.g., "Hurricane Ian," "California Fairview Fire"): _____

Select this SEP if:

- You (or your authorized representative, legal guardian, or person who makes healthcare decisions on your behalf) reside (or resided) in an area for which a federal, state, or local government entity declared a disaster or other emergency.
- You were in your Initial Enrollment Period (IEP), General Enrollment Period (GEP), or another SEP and were not able to enroll in Medicare because of a disaster or other emergency declared by a federal, state, or local entity.

The SEP begins at the start of the emergency or disaster and ends 6 months after the end date identified in the declaration.

Your Part B coverage will begin on the first day of the month following the month of enrollment.

☐ **SEP for Group Health Plan (GHP) or Employer Misrepresentation**

Select this SEP if:

- On or after January 1, 2023, you did not enroll in Part B during your IEP, GEP, or another SEP due to misinformation provided by your employer, GHP, or agent or broker of a health plan.

Please attach documented evidence of the misinformation that is directly from your employer or GHP. The evidence that shows the misinformation was provided prior to the end of your IEP, GEP, or another SEP. If you do not have documented evidence, you will need to provide a written attestation outlining the misinformation. See attachment 1 "Attestation."

This SEP begins after you notify the RRB of the misinformation and ends 6 months later.

Your Part B coverage will begin on the first day of the month following the month of enrollment.

☐ **SEP for Termination of Medicaid Eligibility**

Select this SEP if you have lost or will lose Medicaid coverage on or after January 1, 2023.

The SEP starts when you are notified of the loss of Medicaid coverage and ends 6 months after Medicaid ends.

Coverage Date Options: Chose ***one*** of the following options. If you leave this section blank, your coverage effective date will be Option 1.

☐ **Option 1:** Your coverage will begin the first day of the month following the month of enrollment. Medicare will not cover items or services prior to that date.

☐ **Option 2:** Your coverage will begin the first day of the month in which you lost Medicaid coverage. You will need to pay premiums back to the month you lost Medicaid coverage. Coverage can begin no earlier than January 1, 2023.

Please attach a document or copy of a document from your state or health plan showing the dates your Medicaid coverage will end or has ended. If you do not have documents, the RRB will contact your state to confirm your loss of Medicaid coverage.

☐ **SEP for Formerly Incarcerated Individuals**

Date of Incarceration: __/____ Date of Release (on or after January 1, 2023): __/_____

Select this SEP if you were released within the last 12 months and **ANY** of the following apply:

- Your Medicare was terminated due to non-payment of premiums while you were incarcerated* (meaning the individual is in custody of penal authorities as defined in 42 CFR §411.4).
- You voluntarily terminated your coverage while incarcerated.
- You became eligible for premium Part A or Part B, while incarcerated.

*Individuals who are in custody include, but are not limited to, individuals who are under arrest, incarcerated, imprisoned, escaped from confinement, under supervised release, on medical furlough, required to reside in mental health facilities, required to reside in halfway houses, required to live under home detention, or confined completely or partially in any way under a penal statue or rule.
The SEP starts the day you are released from incarceration and ends the last day of the 12th month in which you were released.

Coverage Effective Date Options: Choose one of the following options. If you leave this section blank, your effective date will be Option 1.

☐ Option 1: Your coverage will begin the first day of the month following the month of enrollment.

☐ Option 2: Your coverage will begin retroactively to the first day of the month of your release from incarceration, not to exceed 6 months. You will need to pay premiums back to the month of your release. Coverage can begin no earlier than January 1, 2023.

☐ **SEP for Other Exceptional Conditions**

Select this SEP if you have a different exceptional condition that occurred on or after January 1, 2023, and is not listed above. You must have proof of the following:

- You experienced circumstances outside of your control that caused you to miss your IEP, GEP, or another SEP.

Please provide a written attestation outlining the condition that caused you to miss an enrollment period. See attachment 1 “Attestation.”

The SEP starts on the day that you notify the RRB, and the duration is determined on a case-by-case basis, but not less than 6 months from the start date.

Your Part B coverage will begin on the first day of the month following the month of enrollment.

5a. Signature (Do **not** print)	5b. Date Signed Month / Day / Year
_____	

6. If this application is signed by mark ("X") in Item 5a, a witness who knows the person signing must complete 6a - 6d below:

6a. Signature of Witness	6b. Date Signed Month / Day / Year
_____	
6c. Address (Number and Street, City, State, and ZIP Code)	6d. Daytime Telephone Number of Witness (____) _____

7. Remarks

8. **For RRB Use Only**	Officially Filed Month / Day / Year	Field Office Number: By:

Special Enrollment Period (SEP) Exceptional Conditions (Attachment 1)

Please use this attachment to provide additional information related to your exceptional condition. We will use the information you provide to determine your eligibility for this SEP.

Your Name	Your SSN or Medicare Number
Date(s) of the incident, if unknown please provide an approximation	Missed Enrollment Period (s) Check all that apply ☐ IEP ☐ GEP ☐ Other SEP

GHP OR EMPLOYER MISREPRESENTATION:

Type of entity that provided the misinformation (Check One) ☐ Employer ☐ GHP ☐ Agent or Broker

Name of the entity that provided the misinformation

Name and title of entity representative (if known)

SEP FOR OTHER EXCEPTIONAL CONDITIONS:

Name of Contact information for additional parties involved (if applicable)

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			

Please use this page to detail any circumstances that may have delayed your or the beneficiary's enrollment, such as exceptional conditions, changes in healthcare insurance while employed, or an inability to attain documentation of healthcare coverage. If you run out of space, please attach a separate sheet to this form.

☐ Check here if an additional sheet is attached.

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 10 minutes per response to complete, including the time for reviewing the instructions, getting the needed data, and reviewing the completed form. Federal agencies may not conduct or sponsor, and respondents are not required to respond to, a collection of information unless it displays a valid OMB number. 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 ATTN: Information Collections Officer in Bureau of Information Services, Railroad Retirement Board, 844 North Rush Street, Chicago, Illinois 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.