

WIDOW/WIDOWER APPLICATION FOR MEDICARE

After completing Items 1 through 11, tab to the receipt on page 8 and complete the top half.



DO NOT WRITE IN THIS SPACE

OFFICIALLY FILED

MONTH	DAY	YEAR

OFFICE NUMBER		

APPROVED _____

APPLICATION NUMBER

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DATE CODED

MONTH	DAY	YEAR

CODED BY _____

Section 1 General Instructions

Print all answers in ink or use a typewriter. If you need more space than is provided to answer a question, use Section 8, for this purpose. If you do not know the answer to a question, print "Unknown" in the space provided for the answer. Also, be sure to read the Important Notices on page 9.

When entering dates, always use numbers. Also, be sure there is one number in each box. For example, you would enter January 1, 2024, as:

MO	DAY	YEAR
0	1	2024

Some items in this application will not apply to you so you will not need to answer them. Based on your answer to a question, you may be told to skip to another item number, or even another section. Follow the instructions that tell you to "Go to" another item. These are designed to save you time and help you move through the application quickly, filling in only necessary information. **Do not skip any items unless directed to do so.**

If you are completing this form on behalf of someone else, you must answer each question as it applies to **the applicant**.

Section 2 Identifying Information

Check the information entered by the Railroad Retirement Board (RRB) for Items 1 through 11 for accuracy.

- If the information is correct, go to Section 3.
- 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	RAILROAD RETIREMENT BOARD CLAIM NUMBER OR SOCIAL SECURITY CLAIM NUMBER, (IF ANY)	_____→	<table border="1"> <tr> <th>PREFIX</th> <th>NUMBER</th> </tr> <tr> <td>A</td> <td></td> </tr> </table>	PREFIX	NUMBER	A	
PREFIX	NUMBER						
A							
3	EMPLOYEE'S NAME	_____→					
4	APPLICANT'S NAME	_____→					
5	a	STREET NAME _____→					
		CITY AND STATE _____→					
		ZIP CODE _____→					

b	FOREIGN ADDRESS _____ (IF YES) COUNTRY _____	<input type="checkbox"/> YES <input type="checkbox"/> NO
6	DAYTIME TELEPHONE NUMBER _____	TELEPHONE NUMBER
7	YOUR DATE OF BIRTH _____	MONTH DAY YEAR
8	YOUR SEX _____	<input type="checkbox"/> MALE ➤ Go to Item 10 <input type="checkbox"/> 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")	
11	ENTER AN "X" IN THE BOX THAT SHOWS YOUR CURRENT FILING STATUS _____	<input type="checkbox"/> WIDOW(ER) <input type="checkbox"/> DIVORCED WIDOW(ER) <input type="checkbox"/> REMARRIED WIDOW(ER)

Section 3 Information about the Employee's Railroad Work and Military Service

12	Has anyone ever filed an application for benefits or Medicare under the Railroad Retirement Act on this account? _____	<input type="checkbox"/> YES ➤ Go to Item 18 <input type="checkbox"/> NO ➤ Go to Item 13 <input type="checkbox"/> UNKNOWN ➤ Go to Item 13
13	Enter the date the employee last worked in the railroad industry. _____	MONTH YEAR
14	Did the employee have 120 or more months of railroad service? _____	<input type="checkbox"/> YES ➤ Go to Item 17 <input type="checkbox"/> NO ➤ Go to Item 15
15	Did the employee have 60 or more months of railroad service after 1995? _____	<input type="checkbox"/> YES ➤ Go to Item 17 <input type="checkbox"/> NO ➤ Go to Item 16
16	Has the employee ever been in active military service in the U.S. Army, Navy, Air Force, Marines, or U.S Space Force? _____	<input type="checkbox"/> YES ➤ Go to Note and Item 17 <input type="checkbox"/> NO ➤ Go to Item 17

Note: If answered "YES," you will have to submit proof of the employee's military service. Please read Chapter 6 of Booklet RB-3, *Furnishing Evidence to Support Your Claim*, to find out where to get proof of military service. If you cannot submit proof, show, in Section 8, the branch of the service and the beginning and ending date for each period of service. Creditable military service may be used to determine your eligibility for Medicare.

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Regardless of whether the employee was retired at death, show the name and address of each railroad or nonrailroad employer for whom the employee performed any part-time or full-time work during the last 3 years he/she worked. Print the name and address of the most recent employer in "A," the second in "B," and so on. Enter the date each job began and ended.

NAME AND ADDRESS OF EMPLOYER			BEGAN		ENDED	
A	NAME		MONTH	YEAR	MONTH	YEAR
	NUMBER AND STREET					
CITY, STATE AND ZIP CODE						
B	NAME		MONTH	YEAR	MONTH	YEAR
	NUMBER AND STREET					
CITY, STATE AND ZIP CODE						
C	NAME		MONTH	YEAR	MONTH	YEAR
	NUMBER AND STREET					
CITY, STATE AND ZIP CODE						

Section 4 Employee's Marital History

18 Was the railroad employee ever married before or after your marriage to him/her?
 YES ➤ Go to Item 19
 NO ➤ Go to Item 20

19 Enter the following information about each of the railroad employee's marriages, beginning with the one in effect when the employee died, if any.

DATE	CITY AND STATE	NAME OF SPOUSE	HOW (CHECK ONE)	DATE	CITY AND STATE
			<input type="checkbox"/> EMPLOYEE'S DEATH <input type="checkbox"/> SPOUSE'S DEATH <input type="checkbox"/> DIVORCE <input type="checkbox"/> ANNULMENT		
			<input type="checkbox"/> SPOUSE'S DEATH <input type="checkbox"/> DIVORCE <input type="checkbox"/> ANNULMENT		
			<input type="checkbox"/> SPOUSE'S DEATH <input type="checkbox"/> DIVORCE <input type="checkbox"/> ANNULMENT		

Section 5 Applicant's Marital History

20	Were you ever married before or subsequent to your marriage to the employee? _____ →	<input type="checkbox"/> YES ➤ Go to Item 21 <input type="checkbox"/> 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	MARRIAGE ENDED
	DATE CITY AND STATE	NAME OF SPOUSE HOW (CHECK ONE) DATE CITY AND STATE
		<input type="checkbox"/> DEATH <input type="checkbox"/> DIVORCE <input type="checkbox"/> ANNULMENT
		<input type="checkbox"/> DEATH <input type="checkbox"/> DIVORCE <input type="checkbox"/> ANNULMENT
		<input type="checkbox"/> DEATH <input type="checkbox"/> DIVORCE <input type="checkbox"/> ANNULMENT

Section 6 Information About Social Security Entitlement

22	Have you ever filed an application for Social Security benefits? _____ →	<input type="checkbox"/> YES ➤ Go to Item 23 <input type="checkbox"/> NO ➤ Go to Section 7										
23	Did you file for Social Security benefits based on your own record? _____ →	<input type="checkbox"/> YES ➤ Go to Section 7 <input type="checkbox"/> NO ➤ Go to Item 24										
24	Enter the name of the person on whose record you filed. _____ →											
25	Enter the Social Security number of the person on whose record you filed. _____ →	<table border="1" style="width: 100%; height: 20px;"> <tr> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> </tr> </table>										

Section 7 Request for Enrollment in Medicare Medical Insurance Part B

In addition to applying for Hospital Insurance under Medicare Part A, you may also 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 sign up during your IEP. If you sign up for Part A and/or Part B during the first 3 months of your Initial Enrollment Period, in most cases, your coverage begins the first day of your birthday month. However, if your birthday is on the first day of the month, your coverage starts the first day of the period month. If you sign up the month you turn 65 or during the last 3 months of your Initial Enrollment Period, your coverage starts the first day of the month after you sign up.

You are eligible for a Special Enrollment Period (SEP) if you are 65 or older, or are under 65 and disabled, and 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) occurs each year from January 1 to March 31. You may enroll in Medicare Part B during the General Enrollment Period if you do not qualify for an IEP or SEP enrollment. If you enroll during the GEP, your Part B effective date begins the month after the month you file your application.

26	Do you wish to enroll in Medicare Part B? _____ →	<input type="checkbox"/> YES > Go to Item 27 <input type="checkbox"/> NO > Go to Section 8
27	Which enrollment period are you filing under? _____ →	<input type="checkbox"/> IEP <input type="checkbox"/> SEP > Go to Item 27a <input type="checkbox"/> GEP
a	<p align="center">Complete this item only if you are filing in a Special Enrollment Period.</p> <p align="center">I want my Part B coverage to begin on the first day of:</p> <p align="center">Month: _____ Year: _____</p> <div style="border: 1px solid black; border-radius: 15px; padding: 5px; margin-top: 10px;"> <p>Note: <i>If you enroll during the last 7 months of a Special Enrollment Period, your Part B coverage will be effective the first day of the month after the month in which you enroll.</i></p> </div>	

Section 8	Remarks
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28	<p>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.</p>
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Section 9 Certification and Attestation

29 Will you have a guardian or other representative sign the application on your behalf?
 YES ➤ Go to "Note" and Item 30
 NO ➤ Go to Item 30

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 certify that the information I gave to the RRB on this application is true to the best of my knowledge. 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 punishable by Federal law that may result in prosecution and/or penalty deductions in my annuity payments.

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 application is signed by mark ("X") in Item 30, 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

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 7 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 8, 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.

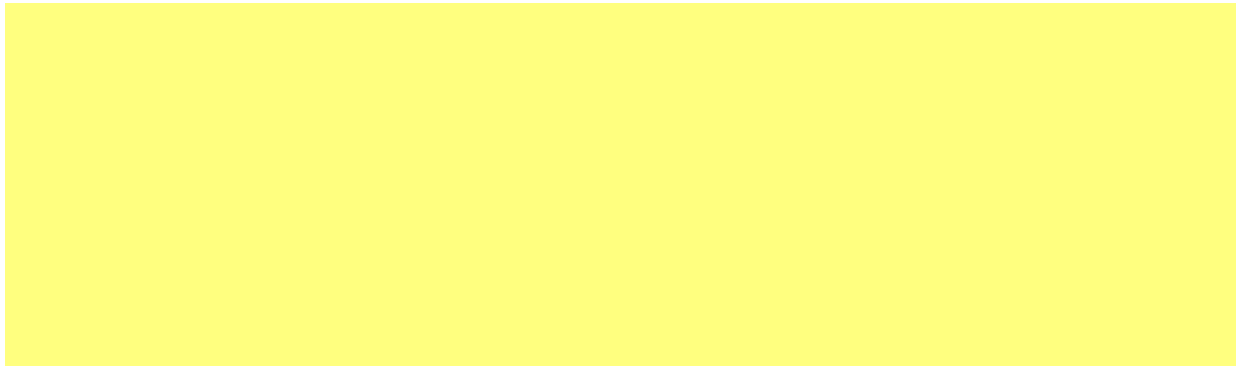
Always Report These Changes to the RRB

- ▶ **Change of Address** – To avoid delay in receipt of RRB correspondence, you should ~~also file a regular~~ report a change of address ~~notice with~~ to the RRB and 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

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 II 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.