Medicare

Request for Enrollment in Medicare Part A (Hospital Insurance)

Use this form to sign up for Medicare Part A if you're 65 or older (or turning 65 in the next 3 months). You can also sign up for Part B (Medical Insurance) with this form.

- If you're eligible for Social Security benefits, you won't pay a premium for Part A.
- If **you aren't** eligible for Social Security benefits, you'll pay a premium for Part A.
- If you're applying after turning 65, you must stop contributing to your Health Savings Account (HSA) before you apply for Medicare to avoid IRS penalties. Visit **IRS.gov** for more information on HSAs.
- If you or your spouse works for a railroad or gets railroad benefits, call the Railroad Retirement Board (RRB) at 1-877-772-5772 to sign up for Medicare.

Visit **Medicare.gov/basics/get-started-with-medicare** to learn more about when you can sign up for Medicare, when your coverage can start, and special situations for people under 65 with a disability.

Submit your form by mail or fax

Mail or fax your completed, signed form to your local Social Security office. Find an office near you at **SSA.gov/locator**.

Get help with this form

- **Phone:** Call Social Security at 1-800-772-1213. TTY users 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.
- For an office near you visit **SSA.gov/locator**.
- **State Health Insurance Assistance Program (SHIP):** Visit **shiphelp.org** to get free, personalized, and unbiased health insurance counseling from your local SHIP.

Get information in another format

You have the right to get Medicare information in an accessible format, like large print, braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit **Medicare.gov/about-us/accessibility-nondiscrimination-notice**, or call 1-800-MEDICARE (1-800-633-4227) for more information. TTY users can call 1-877-486-2048.

Form Approved
OMB No. 0938-0251
Expires: XX/XXXX

Request for Enrollment in Medicare Part A (Hospital Insurance)

Section 1: Basic information

1. Social Security Number (SSN) (or your Medicare Number, if you already have Part B)

SSN: ___ - ___ - ____ Or, Medicare Number: ____ - ____ - ____

2. First name | Middle name | Last name | Suffix

3. Name at birth if different

4. Sex	5. Date of birth (mm/dd/yyyy)	6. State or country of birth (no abbreviations)
◯ Male ◯ Female	__ / __ / ____	

7. Home address (leave blank if you don't have one.)

City	State	ZIP code

8. Mailing address (if different from your home address)

City	State	ZIP code

9. Phone number	10. Email address
(___) ___ - ____	

Section 2: Work history

1. How much were your total W2 earnings last year? If none, write "none."	2. How much do you expect your total W2 earnings to be this year? If none, write "none."

3. Did you work in the railroad industry after January 1, 1937? ..... ◯ Yes ◯ No

Section 3: Citizenship

1. Select the citizenship or immigration status that best describes you:

◯ **U.S. Citizen or National:** I am a citizen or national of the United States. (If selected, skip to Section 4.)

◯ **Lawful Permanent Resident:** I am an alien lawfully admitted for permanent residence under the Immigration and Nationality Act.

◯ **Cuban/Haitian Entrant:** I have been granted status as a Cuban or Haitian entrant.

◯ **Compact of Free Association Resident:** I lawfully reside in the United States under a Compact of Free Association (Marshall Islands, Micronesia, or Palau).

◯ **Other:** I do not meet any of the above categories. (If you select this status, you may not be eligible for Medicare under current federal law.)

If you selected Lawful Permanent Resident, Cuban/Haitian Entrant, or Compact of Free Association Resident, complete items 2–7 below:

2. Alien Registration Number (A-Number), if issued:

3. When were you granted your immigration or citizenship status? (mm/dd/yyyy)

		/			/				
		/			/				

4. Are you currently a resident of the U.S.? ◯ Yes ◯ No

5. When did you become a resident of the U.S.? (mm/dd/yyyy)

		/			/				
		/			/				

6. Have you resided in the U.S. without a break for the past 5 years? ◯ Yes ◯ No

7. List the addresses where you lived for the last 5 years and the dates you lived there. If you need more space, add the information to the remarks space in Section 7.

Address	Started living there (mm/yyyy)	Stopped living there (mm/yyyy)

Section 4: Marital status

1. Are you married? ◯ Yes ◯ No

2. Spouse's first name | Middle name | Last name | Suffix

3. Spouse's date of birth (mm/dd/yyyy) ☐☐/☐☐/☐☐☐☐

4. Spouse's Social Security Number (SSN) ☐☐☐-☐☐-☐☐☐☐

5. Date of marriage (mm/dd/yyyy) ☐☐/☐☐/☐☐☐☐

6. If you aren't married now, did you have a former marriage that lasted 10 or more years *or* ended in death? (**If no,** go to Section 5.) ◯ Yes ◯ No

7. Former spouse's first name | Middle name | Last name | Suffix

8. Former spouse's date of birth (mm/dd/yyyy) ☐☐/☐☐/☐☐☐☐

9. Former spouse's Social Security Number (SSN) ☐☐☐-☐☐-☐☐☐☐

10. Date of former marriage (mm/dd/yyyy) ☐☐/☐☐/☐☐☐☐

11. Date former marriage ended (mm/dd/yyyy) ☐☐/☐☐/☐☐☐☐

12. Date of former spouse's death, if deceased (mm/dd/yyyy) ☐☐/☐☐/☐☐☐☐

13. Do you have another marriage that lasted 10 years or ended in death? ◯ Yes ◯ No

Section 5: Current or prior health coverage and benefits

1. Do you have Medicaid? (**If yes,** skip to Section 6.) ◯ Yes ◯ No

People with Medicaid can get help paying their premiums. For more information, visit: **Medicare.gov/basics/costs/help/medicaid**.

2. Do you currently have (or did you have) coverage through an employer or union group health plan? (**If yes,** complete item 4.) ◯ Yes ◯ No

3. Are you currently (or were you) an international volunteer for a non-profit organization and have or had health coverage provided to you? (**If yes,** complete item 4.) ◯ Yes ◯ No

4. Enter dates of employment (or volunteer work) and health coverage (enter dates as mm/yyyy). Attach a separate sheet if you need more space.

Dates you (or your spouse) worked for an employer that provided health coverage

Start date: ☐☐/☐☐☐☐ End date: ☐☐/☐☐☐☐ ☐ Not ended

Dates you worked as a volunteer outside the U.S.

Start date: ☐☐/☐☐☐☐ End date: ☐☐/☐☐☐☐ ☐ Not ended

Dates of health coverage from employer (or non-profit organization)

Start date: ☐☐/☐☐☐☐ End date: ☐☐/☐☐☐☐ ☐ Not ended

5. Are you (or your spouse) currently getting retirement benefits from the Office of Personnel Management (OPM)? (**If no,** go to Section 6.) ◯ Yes ◯ No

6. Your OPM retirement claim number

7. Your spouse's OPM retirement claim number

8. Do you want to have your Part B premiums deducted from your spouse's retirement benefits? ◯ Yes ◯ No

To select yes, all of these must apply:

- You aren't getting or applying for Social Security benefits
- You aren't eligible to have the state pay your Medicare premium
- Your spouse also has Part B and has Part B premiums deducted from their monthly retirement benefit
- Your spouse provides written consent to have your Part B premiums deducted from their monthly retirement benefit

Section 6: Enrollment in Medicare Part A and Part B

1. If you have to pay a premium for Part A, do you still want to get Part A? ..... ◯ **Yes** ◯ **No**

- If you select yes, you must also sign up for Part B, and you have to pay monthly premiums for both Part A and Part B. Visit **Medicare.gov** for current premium costs.
- If you select no, you won't get Part A or Part B.

2. Do you want to sign up for Part B? (You pay a monthly premium for Part B) ..... ◯ **Yes** ◯ **No**

- If you select yes and you're in an enrollment period, you'll get Part B. Social Security will tell you when you Part B coverage will start. You'll pay a monthly premium for Part B. Visit **Medicare.gov** for Part B costs.
- If you select no and you qualify for Part A without having to pay a premium, you'll just get Part A.

Note: "CMS-L564: Request for employment information" must be completed by your employer if you're signing up for Part A (and have to pay a premium for it) or Part B during a Special Enrollment Period. To download the form, visit **CMS.gov/medicare/cms-forms/cms-forms/downloads/cms-l564e.pdf**.

Section 7: Remarks

Use the space below if you need more room to answer questions in Section 3 or Section 5.

Section 8: Signature(s)

1. Are you completing this application for someone else? ..... ◯ Yes ◯ No

If yes, what's your name and relationship to the person applying?

Name	Relationship to applicant

By signing this application, I understand that the information I entered will be used to process my application for Medicare. I understand that if I intentionally provide false information on this form, it is a crime punishable under Federal law by fine, imprisonment, or both. I declare under penalty of perjury that the information I entered is true and correct to the best of my knowledge.

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.

2. Signature of applicant	**3. Date signed (mm/dd/yyyy)**
	__ __ / __ __ / __ __ __ __

If this form has been signed by mark (X), a witness who knows the person applying must also sign below:

4. Name of witness (first and last name)

5. Signature of witness	6. Date signed (mm/dd/yyyy)
	__ __ / __ __ / __ __ __ __

Submit your form by mail or fax

Mail or fax your completed, signed form to your local Social Security office. Find an office near you at **SSA.gov/locator**.

Privacy Act Statement

Social Security is authorized to collect your information under sections 1836, 1840, and 1872 of the Social Security Act, as amended (42 U.S.C. 1395o, 1395s, and 1395ii) for your enrollment in Medicare Part B. Social Security and the Centers for Medicare & Medicaid Services (CMS) need your information to determine if you're entitled to Part B. While you don't have to give your information, failure to give all or part of the information requested on this form could delay your application for enrollment. Social Security and CMS will use your information to enroll you in Part B. Your information may be also be used to administer Social Security or CMS programs or other programs that coordinate with Social Security or CMS to: 1) Determine your rights to Social Security benefits and/or Medicare coverage. 2) Comply with Federal laws requiring Social Security and CMS records (like to the Government Accountability Office and the Veterans Administration). 3) Assist with research and audit activities necessary to protect integrity and improve Social Security and CMS programs (like to the Bureau of the Census and contractors of Social Security and CMS). We may verify your information using computer matches that help administer Social Security and CMS programs in accordance with the Computer Matching and Privacy Protection Act of 1988 (P.L. 100-503).