Revisions to Form CMS 18F5 (OMB 0938-1251)
Request for Enrollment in Medicare Part A (Hospital Insurance)

The form was revised to add a new citizenship section to verify the applicant's citizenship or immigration status, in alignment with the addition of Section 1899C of the Social Security Act, as amended by Section 71201 of the Working Families Tax Cut (WFTC) (Pub. L. 119-21). The form was also updated to add the optional collection of email addresses. CMS' Office of Communications provided feedback on the form design and the layout of the questions. The form was redesigned to give the applicants a more user-friendly experience. No additional changes were made, and the burden was not impacted by the changes.

Changes	Updated Form	Original Form	Reason for Change	Burden Effect
Updated cover page 1	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	Who can use this application? People age 65 and older (and those turning 65 in the next 3 months) who want to apply for Part A. Part A covers hospital care and more. Note: If you or your spouse works for a railroad or gets railroad benefits, call the Railroad Retirement Board (RRB) at 1-877-772-5772. When do you use this application? Use this form: • If you're eligible for Social Security	CMS Office of Communications suggestions.	N/A

	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.	benefits but only want to get Medicare. You must be at least 64 and 8 months. (You won't pay a premium for Part A.) • If you're not eligible for Social Security benefits and want to sign up for Part A. You can sign up only during certain times—for more details go to the next page. (You'll pay a premium for Part A.) Note: Because you're signing up for Part A, you can also sign up for Part B (Medical Insurance) with this form. Part B covers doctors' services and more. What information do you need to complete this application? You will need your: • Social Security Number (SSN) • Date of birth •		

		Current address and phone number • Work history • Form CMS-L564 "Medicare Request for Employment Information" 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. What happens next? Send your completed and signed application (pages 1–2) to your local Social Security office. If you have questions, call Social Security at 1-800-772-1213. TTY users can call 1-800-325-0778. How do you get help with this application? • Phone: Call Social Security at 1-800-772-1213. TTY users can call 1-800-325-0778. • In		

		person: Visit your local Social Security office. Find an office near you at SSA.gov/locator. • 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. Health Savings Account (HSA) If you're applying after reaching the age of 65, you must stop contributing to your HSA before applying for Medicare to avoid IRS penalties. Premium-free Part A coverage starts up to 6 months back from when you apply (but not earlier than the month you turned 65). Visit IRS.gov for more on HSAs. Reminder If you		

		have to pay a premium for Part A, or if you also sign up for Part B, you must pay premiums for every month you have the coverage. You have the right to get Medicare information in an accessible form, 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.		
Deleted Cover Page 2	N/A	When you can apply for Part A (if you have to pay a premium for it) and Part B Initial	CMS Office of Communications suggestions.	N/A

		Enrollment Period This is the first chance you have to apply. It lasts for 7 months. It begins 3 months before the month you turn 65, and it ends 3 months after you turn 65. Coverage will begin the month after you sign up. General Enrollment Period (January 1–March 31 each year) If you sign up during this time, your coverage will start the month after you sign up. In most cases, you'll have to pay a late enrollment penalty. The penalty is added to your monthly premium, and it goes up the longer you go without coverage. • Part A penalty: If you have to pay a premium for Part A, your premium will go up 10%. You'll pay it		

		for twice the number of years you didn't sign up. • Part B penalty: Your Part B premium will go up 10% for each 12-month period that you could have had Part B but didn't sign up. You'll pay it for as long as you have Part B coverage. Special Enrollment Period • Working aged/disabled: You have a Special Enrollment Period if you're covered under a group health plan based on current employment. To use this Special Enrollment Period, you must: • Be 65 or older and currently employed • Be the spouse of an employed person, and covered under your spouse's employer group health plan based on		

		his/her current employment • Be under 65 and disabled, and covered under a group health plan based on your own or your spouse's current employment You can sign up anytime while you have group health plan coverage based on current employment or during the 8 months after either the coverage ends or the employment ends, whichever happens first. If you sign up while you have group health plan coverage based on current employment, or, during the first full month that you no longer have this coverage, your coverage will begin the first day of the month you sign up. You can also choose		

		to have your coverage begin within any of the following 3 months. If you sign up during any of the remaining 7 months of your Special Enrollment Period, your coverage will begin the month after you sign up. Note: COBRA coverage or a retiree health plan is not considered group health plan coverage based on current employment. • International volunteers: You have a Special Enrollment Period if you were volunteering outside of the United States for at least 12 months for a tax-exempt organization and had health insurance (through the organization) that provided		

		coverage for the duration of the volunteer service. If you think you may be eligible for a Special Enrollment Period, contact Social Security at 1-800-772-1213. TTY users can call 1-800-325-0778. Visit Medicare.gov to learn more about when you can sign up and special situations for people under 65 with a disability.		
Numbered section	Section 1: Basic Information	1. Tell us about Yourself. We need this information to find you in our records.	Section labels added to better organize the content and align with other Medicare Part B enrollment forms.	N/A
Renumbering	1. Social Security Number (SSN) (or your Medicare Number, if you already have Part B)	1a. Your Social Security Number (SSN) (or your Medicare Number, if you already have Part B)	Questions renumbered for better organization.	N/A

Renumbering, rephrase question	2. First name Middle name Last name Suffix	1b. Your name (last name, first name, middle name)	Questions renumbered for better organization.	N/A
Renumbering, rephrase question	3. Name at birth if different	1c. Your name as it appears on your birth certificate, if different than item 1b	Questions renumbered for better organization and rephrased for clarity.	N/A
Renumbering	4. Sex	1d. Sex	Questions renumbered for better organization.	N/A
Renumbering	5. Date of birth (mm/dd/yyyy)	1e. Date of birth (mm/dd/yyyy)	Questions renumbered for better organization.	N/A
Renumbering	6. State or country of birth (no abbreviations)	1f. State or country of birth (no abbreviations)	Questions renumbered for better organization.	N/A
Renumbering	7. Home address (leave blank if you don't have one.)	1g. Mailing address (number and street, PO Box, or route)	Questions renumbered for better organization.	N/A
Renumbering	8. Mailing address (if different from your home address)	1h. Address of permanent residence, if different from your mailing address	Questions renumbered for better organization.	N/A
Renumbering	9. Phone number	1i. Phone Number	Questions renumbered for	N/A

			better organization.	
Renumbering	10. Email address	1j. Email address	Questions renumbered for better organization.	N/A
Added Section 2: Citizenship	**Section 2: Work history**	2.Tell us about your work history	Section labels added to better organize the content and align with other Medicare Part B enrollment forms.	N/A
Renumbering	1. How much were your total W2 earnings last year? If none, write “none.”	2a. How much were your total earnings last year? If none, write “none.”	Questions renumbered for better organization.	N/A
Renumbering	2. How much do you expect your total W2 earnings to be this year? If none, write “none.”	2b. How much do you expect your total earnings to be this year? If none, write “none.”	Questions renumbered for better organization.	N/A
Renumbering	3. Did you work in the railroad industry after January 1, 1937?	2c. Did you work in the railroad industry after January 1, 1937?	Questions renumbered for better organization.	N/A
Numbered section	Section 3: Employment Information	3.Tell us about your citizenship	Section labels added to better organize the content and align with other Medicare Part B	N/A

			enrollment forms.	
Updated citizenship question	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.? 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? 7. List the addresses where you lived for the last 5 years and the dates you lived there. If you need more space,	3a. Are you a U.S. citizen? (If yes, go to item 4. 3b. Are you lawfully present in the U.S.? (If no, go to item 4.) 3c. When did you become lawfully present in the U.S.? (mm/dd/yyyy) 3d. Are you currently a resident of the U.S.? 3e. When did you become a resident of the U.S.? (mm/dd/yyyy) 3f. Have you resided in the U.S. without a break for the past 5 years? 3g. Enter where you lived for the last 5 years and the dates you lived there. Attach a separate sheet if you need more space. 3h. Have you been outside the U.S. in the last 5 years?	In alignment with the addition of Section 1899C, the Form CMS-4040 has been updated to include a citizenship section to verify the applicant's citizenship or immigration status.	N/A

	add the information to the remarks space in Section 7.			
Numbered section	**Section 4: Marital status**		Section labels added to better organize the content and align with other Medicare Part B enrollment forms.	N/A
Renumbered	1. Are you married?.	4a. Are you currently married?	Questions renumbered for better organization and rephrased for clarity.	N/A
Renumbered	2. Spouse's first name Middle name Last name Suffix	4b. Spouse's name (last name, first name, middle name)	Questions renumbered for better organization and rephrased for clarity.	N/A
Renumbered	3. Spouse's date of birth (mm/dd/yyyy)	4c. Spouse's date of birth (mm/dd/yyyy)	Questions renumbered for better organization and rephrased for clarity.	N/A
Renumbered	4. Spouse's Social Security Number (SSN)	4d. Spouse's Social Security Number (SSN)	Questions renumbered for better organization and	N/A

			rephrased for clarity.	
Renumbered	5. Date of marriage (mm/dd/yyyy)	4e. Date of marriage (mm/dd/yyyy)	Questions renumbered for better organization and rephrased for clarity.	N/A
Renumbered	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.)	4f. If you are not married now, did you have a former marriage that lasted 10 or more years OR ended in death? Yes No (If no, go to item 5.)	Questions renumbered for better organization and rephrased for clarity.	N/A
Renumbered	7. Former spouse's first name Middle name Last name Suffix	4g. Name of former spouse (last name, first name, middle name)	Questions renumbered for better organization and rephrased for clarity.	N/A
Renumbered	8. Former spouse's date of birth (mm/dd/yyyy)	4h. Former spouse's date of birth (mm/dd/yyyy)	Questions renumbered for better organization and rephrased for clarity.	N/A
Renumbered	9. Former spouse's Social Security Number (SSN)	4i. Spouse's Social Security Number (SSN)	Questions renumbered for better organization and	N/A

			rephrased for clarity.	
Renumbered	10. Date of former marriage (mm/dd/yyyy)	4j. Date of former marriage (mm/dd/yyyy)	Questions renumbered for better organization and rephrased for clarity.	N/A
Renumbered	11. Date former marriage ended (mm/dd/yyyy)	4k. Date former marriage ended (mm/dd/yyyy)	Questions renumbered for better organization and rephrased for clarity.	N/A
Renumbered	12. Date of former spouse's death, if deceased (mm/dd/yyyy)	4l. Date of former spouse's death, if deceased (mm/dd/yyyy)	Questions renumbered for better organization and rephrased for clarity.	N/A
Renumbered	13. Do you have another marriage that lasted 10 years or ended in death?	4m. Do you have another marriage that lasted 10 years or ended in death?	Questions renumbered for better organization and rephrased for clarity.	N/A
Numbered section	**Section 5: Current or prior health coverage and benefits**	**Section 5: Current or prior health coverage and benefits**	Section labels added to better organize the content and align with other Medicare Part B enrollment	N/A

			forms. Sections renumbered for organization.	
Renumbered	1. Do you have Medicaid? (If yes, skip to Section 6.) 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.) 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.) 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.) 6. Your OPM retirement claim number 7. Your spouse's OPM retirement claim number	5a. If you have to pay a premium for Part A, do you still want to get Part A? Yes No (If yes, you must also sign up for Part B, and you have to pay monthly premiums.) 5b. Do you want to sign up for Part B? (You pay a monthly premium for Part B.)	Section labels added to better organize the content and align with other Medicare Part B enrollment forms. Sections renumbered for organization.	N/A

	8. Do you want to have your Part B premiums deducted from your spouse's retirement benefits? 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			
Numbered section	Section 6: Enrollment in Medicare Part A and Part B	6.Tell us about your current or prior health coverage and benefits	Section labels added to better organize the content and align with other Medicare Part B enrollment forms. Sections renumbered for organization.	N/A
Renumbered	1. If you have to pay a premium for Part A, do you still want to get Part A? • 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)	6a. Do you have Medicaid? (People with Medicaid can get help paying their premiums. If yes, go to item 7.) 6b. Do you currently have (or did you have) coverage through an employer	Questions renumbered for better organization and rephrased for clarity.	N/A

	• 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.	or union group health plan? (If yes, complete item 6d.) 6c. 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 6d.) 6d. Enter dates of employment (or volunteer work) and health coverage (enter all dates as mm/dd/yyyy). Attach a separate sheet if you need more space. Dates you (or your spouse) worked for employer that provided health coverage: Dates of health coverage from employer (or non-profit organization): Dates you worked as a volunteer outside		

		the U.S.: Start date: End date: Not ended Start date: End date: Not ended Start date: End date: Not ended 6e. Are you (or your spouse) currently getting retirement benefits from the Office of Personnel Management (OPM)? Yes No (If no, go to item 7.) 6f. Your OPM retirement claim number 6g. Your spouse's OPM retirement claim number 6h. Do you want to have your Part B premiums deducted from your spouse's retirement benefits? (See instructions on page 8 before you answer.)		
Optional remarks section	Section 7: Remarks	N/A	Added to allow applicants to provide	N/A

			additional context	
Numbered section	Section 8: Signature(s)	7.Sign your application	Section labels added to better organize the content and align with other Medicare Part B enrollment forms. Sections renumbered for organization.	
Renumbered	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	7a. If you are completing this application for someone else, what's your name and your relationship to the person applying? 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	Questions renumbered for better organization and rephrased for clarity.	

	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)	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. 7b. Written signature (do not print) If this application has been signed by mark (X), a witness who knows the person applying must also sign this form. 7c. Date signed 7d. Name of witness (first and last name) 7e. Signature of witness 7f. Date signed		

		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 signed Printed name of witness Signature of witness Date signed		

Remove Instructions	N/A	Step-by-step instructions for form CMS-18-F-5	Instructions removed for organization.	N/A
Updated Privacy Act Statement	Updated OMB control number and time estimate fields (currently listed as 0938-XXXX and XX minutes)	Previously approved OMB control number and time estimate	Placeholder values to be updated upon OMB approval.	N/A
Updated Paperwork Reduction Act Statement	Updated OMB control number and time estimate fields (currently listed as 0938-XXXX and XX minutes)	Previously approved OMB control number and time estimate	Placeholder values to be updated upon OMB approval.	N/A