DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

TOE 810
Form approved
OMB. No. 0938-0245

Do Not Write In This Space

REQUEST FOR ENROLLMENT IN SUPPLEMENTARY MEDICAL INSURANCE

According to the Paperwork Reduction of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection of 0938-0245. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, N2-14-26, Baltimore, Maryland 21244-1850.

PRIVACY ACT NOTICE: The Social Security Administration (SSA) is authorized to collect the information on this form under sections 1836, 1840, and 1872 of the Social Security Act, as amended (42 U.S.C. 1395o, 1395s, and 1395ii). The information on this form is needed to enable Social Security and the Centers for Medicare & Medicaid Services (CMS) to determine if you are entitled to supplementary medical insurance benefits. While you do not have to furnish the information requested on this form to Social Security, no medical insurance can be provided until an application has been received by the Social Security office. Failure to provide all or part of the information requested could prevent an accurate and timely decision on your application for enrollment or could be cause for denial of insurance entitlement. 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 Social Security or CMS programs or for the administration of programs requiring coordination with SSA or CMS, information may be disclosed to another person or to another governmental agency as follows: 1) to enable a third party or an agency to assist Social Security or CMS in establishing rights to Social Security benefits and/or hospital or medical insurance coverage; 2) to comply with Federal laws requiring the release of information from Social Security and CMS records (e.g., to the General Accounting Office and the Veterans Administration); and 3) to facilitate statistical research and audit activities necessary to assure the integrity and improvement of the Social Security and CMS programs (e.g., to the Bureau of the Census and private concerns under contract to Social Security and CMS). In addition, you should be aware that the information you provide may be verified by way of computer matches in accordance with the Computer Matching and Privacy Protection Act of 1988 (P.L. 100-503).

I wish to enroll in Medicare's supplementary medical insurance benefits plan described under title XVIII of the Social Security Act, as presently amended. I understand that a premium payment will be due for each month of coverage under this plan. (See reverse side for further explanation.)

1.	a. PRINT your name	(FIRST NAME, MIDDLE INITIAL, LAST NAME)
	b. Enter your name at birth if different from 1(a)	
	c. Enter your sex (check one)	☐ Male ☐ Female
	d. Enter your Social Security Number	___ ___ ___ / ___ ___ / ___ ___ ___ ___
2.	a. Enter your date of birth (Month, day, year)	
	b. Enter name of State or foreign country where you were born	
	If you have not submitted proof of your age complete (c) and (d). c. Was a public record of your birth made before you were age 5?	☐ Yes ☐ No ☐ Unknown
	d. Was a religious record of your birth made before you were age 5?	☐ Yes ☐ No ☐ Unknown
3.	Have you ever before enrolled for supplementary medical insurance under Medicare?	☐ Yes ☐ No
4.	a. Do you or your spouse receive a monthly annuity under the Federal Civil Service Retirement Act or other law administered by the Office of Personnel Management? *(If "Yes," answer (b). If "No," go on to item 5.)*	☐ Yes ☐ No
	b. Enter the Civil Service annuity number here. *(Include the prefix, i.e., "CSA" for annuitant, "CSF" for survivor.)*	YOUR NO. __ __ __ __ __ __ __ __ __ __ __ SPOUSE'S NO.
	If you entered your spouse's number, is he (she) enrolled for supplementary medical insurance?	☐ Yes ☐ No

If you are entitled to Medicare's hospital insurance omit items 5 and 6.

5.	Are you a resident of the United States? *(To reside in a place means to make a home there.)*	☐ Yes	☐ No
6.	a. Are you a citizen of the United States? *(If "Yes," omit items b. and c. If "No," answer b. and c. below.)*	☐ Yes	☐ No
	b. Are you lawfully admitted for permanent residence in the United States?	☐ Yes	☐ No
	c. Enter below the information requested about your place of residence in the last 5 years.		

ADDRESSES AT WHICH YOU RESIDED IN THE LAST 5 YEARS *(Begin with the most recent address. Show actual date residence began even if that is prior to the last 5 years.)*	**DATE RESIDENCE BEGAN**			**DATE RESIDENCE ENDED**		
	Month	**Day**	**Year**	**Month**	**Day**	**Year**

(If you need more space, use the "Remarks" space or another sheet of paper)

PAYING YOUR PREMIUM

If you sign up for medical insurance, you must pay a premium for each month you have this protection. If you get monthly Social Security, railroad retirement, or civil service benefits, your premium will be deducted from your benefit check. If you get none of these benefits, you will be notified how to pay your premium.

The Federal Government contributes to the cost of your insurance. The amount of your premium and the Government's payment are based on the cost of services covered by medical insurance. The Government also makes additional payments when necessary to meet the full cost of the program. (Currently, the Government pays three-quarters of the cost of this program.) You will get advance notice if there is any change in your premium amount.

Remarks

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.

SIGNATURE OF APPLICANT	Date *(Month, day, year)*
Signature *(First name, middle initial, last name) (Write in ink)* SIGN HERE	Telephone Number
Mailing Address *(Number and street, Apt. No., P.O. Box, or Rural Route)*	

City	State	ZIP Code	Enter Name of County (if any) in which you now live

Witnesses are required ONLY if this application has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the applicant must sign below, giving their full addresses.

1. Signature of Witness	2. Signature of Witness
Address *(Number and street, City, State and ZIP Code)*	Address *(Number and street, City, State, and ZIP Code)*