



Medicare

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

Use this form to sign up for Medicare Part A (Hospital Insurance) or Part B (Medical Insurance) during a Special Enrollment Period because of an exceptional situation.

Some common reasons for qualifying include being impacted by a natural emergency or disaster, losing Medicaid coverage, or being released from jail. You'll need to provide written proof that you experienced circumstances outside of your control that prevented you from enrolling in Medicare during your Initial Enrollment Period or another valid enrollment period.

Learn more about Medicare enrollment periods (including Special Enrollment Periods) at [Medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start](https://www.Medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start).

When is your Initial Enrollment Period?

Your Initial Enrollment Period is the first chance you have to sign up for Medicare Part B. It lasts for 7 months. It begins 3 months before the month you reach 65, and ends 3 months after the month you reach 65. If you have Medicare due to disability, your Initial Enrollment Period begins 3 months before the 25th month of getting Social Security Disability.

- If you have a Health Savings Account (HSA), you must stop contributing 6 months before you apply for Medicare so you won't be penalized by the IRS. Get more information about HSA penalties at [IRS.gov](https://www.irs.gov).
- If you sign up after your Initial Enrollment Period, you may have to pay a late enrollment penalty of 10% for each full 12-month period you don't have Part B but were eligible to sign up.

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](https://www.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.
- **In person:** Visit your local Social Security office for in-person help. Find an office near you at [SSA.gov/locator](https://www.SSA.gov/locator).
- **State Health Insurance Assistance Program (SHIP):** Visit [shiphelp.org](https://www.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](https://www.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.

Application for Medicare Part A and Part B Special Enrollment Period (Exceptional Circumstances)

Section 1: Basic information

Social Security Number (SSN) or Medicare Number, if you have one

SSN: - - Or, Medicare Number: - -

First name

Middle name

Last name

Suffix

Name at birth if different

Sex

☐ Male ☐ Female

Date of birth (mm/dd/yyyy)

/ /

State or country of birth (no abbreviations)

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

City

State

ZIP code

Mailing address (if different from home address)

City

State

ZIP code

Phone number

() -

Email address

Do you want to sign up for Medicare Part B (Medical Insurance)?.....☐ Yes ☐ No

Section 2: 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:

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

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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)

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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 3.

Address	Started living there (mm/yyyy)	Stopped living there (mm/yyyy)												
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Section 3: Remarks

Use the space below if you need more room to answer questions in Section 2.

Section 4: Special Enrollment Period for Exceptional Conditions

Select the Special Enrollment Period that best fits your situation. If none of these apply to you, contact Social Security at 1-800-772-1213 to see if there are other available options. TTY users can call 1-800-325-0778.

☐ Impacted by an emergency or natural disaster

Select this Special Enrollment Period if:

- You live (or lived) in an area for which a federal, state or local government entity declared a disaster or other emergency.
- The disaster or emergency prevented you from enrolling in Medicare during your Initial Enrollment Period or other valid enrollment period.

The Special Enrollment Period begins at the start of the emergency or disaster, and ends 6 months after the declared end date.

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

Start date (mm/yy): / End date (mm/yy): /

Optional description of emergency (e.g. "Hurricane Ian," "California Fairview Fire"):

☐ Group Health Plan or employer misrepresentation

Select this Special Enrollment Period if:

- Incorrect or misleading information you got directly from your employer, a group health plan, or agent or broker of a health plan prevented you from enrolling in Medicare Part B during your Initial Enrollment Period or other valid enrollment period.
- This happened on or after January 1, 2023.

This Special Enrollment Period starts the day you notify Social Security of the incorrect information and ends 6 months later.

You must attach documents from the employer or health plan that show evidence of the incorrect or misleading information (for example, a letter or website notice). The evidence must show that you got the incorrect information before the end of your Initial Enrollment Period or other valid enrollment period. If you don't have any evidence, you need to give a written statement that explains how incorrect information prevented you from enrolling in Medicare. **Use the "Attestation" form on page 5.**

☐ Lost Medicaid eligibility

Select this Special Enrollment Period if you lost Medicaid coverage on or after January 1, 2023.

The Special Enrollment Period starts when you're notified that you lost Medicaid coverage and ends 6 months after your Medicaid ends.

When do you want Medicare coverage to start?

Choose **one**. If you leave this section blank, your coverage start date will be option 1.

- ☐ **Option 1:** Your coverage will start the first day of the month **after** the month you enroll. Medicare won't cover any items or services before that date.
- ☐ **Option 2:** Your coverage will start the first day of the month you lost Medicaid coverage. If you choose this option, you'll need to pay back Medicare premiums for every month since you lost Medicaid.

You must attach a document (or copy) from your state or health plan showing the date your Medicaid coverage will end (or ended). If you don't have documents, Social Security will contact your state to confirm you lost Medicaid.

☐ **Released from incarceration**

Select this Special Enrollment Period 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.
- You voluntarily terminated your coverage while incarcerated.
- You became eligible for Medicare Part A or Part B while you were incarcerated.

The Special Enrollment Period starts the day you're released from custody and ends the last day of the 12th month after the month you were released. Release must be on or after January 1, 2023.

* Incarcerated refers to individuals who are confined in a jail, prison, or other penal institution or correctional facility. Note, individuals released from confinement to residency in halfway houses are not considered incarcerated for purposes of enrollment using this Special Enrollment Period.

Date of incarceration (mm/yy): / Date of release (mm/yy): /

When do you want Medicare coverage to start?

Choose **one**. If you leave this section blank, your coverage start date will be option 1.

- ☐ **Option 1:** Your coverage will start the first day of the month after the month you enroll.
- ☐ **Option 2:** Your coverage will start the first day of the month you were released (up to 6 months back). If you choose this option, you'll need to pay back Medicare premiums for every month since your release.

☐ **Other exceptional conditions**

Select this Special Enrollment Period if you have a different exceptional condition that occurred on or after January 1, 2023 that isn't listed above. You must attach proof that shows you experienced circumstances outside of your control that prevented you from enrolling in Medicare during a valid enrollment period.

Use the "Attestation" form on page 5 to explain the condition that prevented you from enrolling in Medicare during a valid enrollment period.

The Special Enrollment Period starts the day you notify Social Security of your situation. The end of this Special Enrollment Period will be determined on a case-by-case basis, but will be at least 6 months from the start date.

Section 5: Signature(s)

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

Date signed (mm/dd/yyyy)

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

Name of witness (first and last name)

Signature of witness

Date signed (mm/dd/yyyy)

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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](https://www.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).

Paperwork Reduction Act: According to the Paperwork Reduction Act 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 is 0938-1426. The time required to complete this information 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, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850. Important: Do not send this form or any items with your personal information (such as claims, payments, medical records, etc.) to the PRA Reports Clearance Office. Any items we get that aren't about how to improve this form or its collection burden (outlined in OMB 0939-0251) will be destroyed. It will not be kept, reviewed, or forwarded to Social Security or any other agency.

Special Enrollment Period for Exceptional Conditions Attestation (Attachment 1)

First name

Middle name

Last name

Suffix

Social Security Number (SSN) or Medicare Number, if you have one

SSN: -- Or, Medicare Number: --

Date(s) the condition happened (estimate if you need to)

Missed Enrollment Period(s). Check all that apply:

☐ Initial Enrollment Period

☐ General Enrollment Period

☐ Other Special Enrollment Period

Use this space to explain your exceptional condition in detail and how it prevented you from enrolling in Medicare. If other people were involved, give their names and titles and explain how they were involved.

If you run out of space, attach a separate sheet. ☐ Check here if an additional sheet is attached.

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 (mm/dd/yyyy)

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