



Medicare

Request for Enrollment in Medicare Part B (Medical Insurance)

Use this form to enroll in Medicare Part B if you're **NOT** entitled to Social Security/Railroad Retirement Board benefits. You can use this form to enroll during your Initial Enrollment Period when you're first eligible for Medicare.

Once you enroll in Medicare Part B, you must pay premiums for every month you have coverage.

Note: If you're entitled to Social Security/Railroad Board benefits use CMS-40B Request for Enrollment in Medicare Part B (Medical Insurance). You can find the application on [CMS.gov](https://www.cms.gov), or contact Social Security at 1-800-772-1213 for a copy. TTY users can call 1-800-325-0778.

Important! You must submit an original birth certificate with your form, or religious record of your birth that was made before you were age 5. We must see the original document or copies certified by the agency that issued them. We will return all your documents to you. Get more information at [SSA.gov/help/iClaim_poa.html](https://ssa.gov/help/iClaim_poa.html).

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://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 and a copy of your birth record to your local Social Security office. Find an office near you at [SSA.gov/locator](https://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://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](https://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.

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Section 1: Basic information

First name	Middle name	Last name	Suffix
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Name as it appears on your birth certificate, if different than above

Sex ☐ Male ☐ Female	Social Security Number (SSN) <table border="1"><tr><td></td><td></td><td></td><td></td><td>-</td><td></td><td></td><td></td><td>-</td><td></td><td></td><td></td><td></td></tr></table>					-				-				
				-				-						

Date of birth (mm/dd/yyyy) <table border="1"><tr><td></td><td></td><td></td><td></td><td>/</td><td></td><td></td><td></td><td>/</td><td></td><td></td><td></td><td></td><td></td></tr></table>					/				/						State or country of birth
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Note: A record of birth is **required**. Submit your original birth certificate, or a religious record of your birth before age 5. Get more information at [SSA.gov/help/iClaim_poa.html](https://ssa.gov/help/iClaim_poa.html).

Phone number (<table border="1"><tr><td></td><td></td><td></td></tr></table>) <table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr></table> - <table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>																Email address

Have you ever been enrolled in Medicare Part B before? ☐ Yes ☐ No ☐ Unknown

Do you or your spouse get a monthly annuity under the Federal Civil Service Retirement Act, or other law administered by the Office of Personnel Management? ☐ Yes ☐ No

If yes, enter the civil service annuity (CSA) number for you or your spouse:

CSA -

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If you entered your spouse's CSA number, is your spouse enrolled in Medicare Part B? ☐ 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:

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 3.

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

Section 3: Remarks

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

Section 4: Signature(s)

Signature

Date signed (mm/dd/yyyy)

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Mailing address

City

State

ZIP code

Country

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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 and your original birth record 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 0938-0245. The time required to complete this information is estimated to average 10 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.