

APPLICATION FOR ENROLLMENT IN MEDICARE PART B (MEDICAL INSURANCE)

1. Your Medicare Number

2. Do you wish to sign up for Medicare Part B (Medical Insurance)? YES

3. Your Name (Last Name, First Name, Middle Name)

4. Mailing Address (Number and Street, P.O. Box, or Route)

5. City

State

Zip Code

6. Phone Number (including area code)

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7. Written Signature (DO NOT PRINT)

SIGN HERE

8. Date Signed

 / /

**IF THIS APPLICATION HAS BEEN SIGNED BY MARK (X), A WITNESS WHO KNOWS THE APPLICANT
MUST SUPPLY THE INFORMATION REQUESTED BELOW.**

9. Signature of Witness

10. Date Signed

 / /

11. Address of Witness

12. Remarks

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 0938-1230. 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.

REQUEST FOR EMPLOYMENT INFORMATION

SECTION A: To be completed by individual signing up for Medicare Part B (Medical Insurance)

1. Employer's Name		2. Date	
		□□ / □□ / □□□□	
3. Employer's Address			
City		State	Zip Code
		□□	□□□□□□
4. Applicant's Name		5. Applicant's Social Security Number	
		□□□□ - □□ - □□□□□□	
6. Employee's Name		7. Employee's Social Security Number	
		□□□□ - □□ - □□□□□□	

SECTION B: To be completed by Employers

For Employer Group Health Plans ONLY:

1. Is (or was) the applicant covered under an employer group health plan?	Yes	No
2. If yes, give the date the applicant's coverage began. (mm/yyyy)		
□□ / □□□□		
3. Has the coverage ended?	Yes	No
4. If yes, give the date the coverage ended. (mm/yyyy)		
□□ / □□□□		
5. When did the employee work for your company?		
From: (mm/yyyy)	To: (mm/yyyy)	Still Employed: (mm/yyyy)
□□ / □□□□	□□ / □□□□	□□ / □□□□
6. If you're a large group health plan and the applicant is disabled, please list the timeframe (all months) that your group health plan was primary payer.		
From: (mm/yyyy)	To: (mm/yyyy)	
□□ / □□□□	□□ / □□□□	

For Hours Bank Arrangements ONLY:

1. Is (or was) the applicant covered under an Hours Bank Arrangement?	Yes	No
2. If yes, does the applicant have hours remaining in reserve?	Yes	No
3. Date reserve hours ended or will be used? (mm/yyyy)		
□□ / □□□□		

All Employers:

Signature of Company Official	Date Signed
	□□ / □□ / □□□□
Title of Company Official	Phone Number
	(□□□□) □□□□ - □□□□

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 is 0938-0787. 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 comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, MD 21244-1850.