Medicare How to Apply Part B

Part A - will issue automatically if you qualify (work 10 years in US)
Part B – Under 65 must apply online or in person at SSA office.
Over 65 must apply paper or secure fillable application or in person at SSA office.
Already collecting Social Security retirement income Part B is automatically awarded.

If you are **under 65:** you can apply on-line > 3 months before your birthday month at https://www.ssa.gov/ Or set an appointment at your local social security office - bring your information with you - look below.

If you are **over 65** years of age you **must** apply with a paper application form CMS 40B along with form CMS L564 employer form or in Person at local social security office - bring information with you – look below.

Another way to file – You can file at https://secure.ssa.gov/mpboa/medicare-part-b-online-application/ you must upload proof of prior coverage, or you can go set appointment at local SSA office see attached pages.

When completing the forms CMS-40B and CMS-L564:

State "I want Part B coverage to begin (MM/YY)" in the remarks section of the CMS-40B form or online application.

If possible, your employer should complete Section B.

If employer is unable to complete Section B, please complete that portion as best as you can on their behalf and submit one of the following forms of secondary evidence:

Over 65 Submit these forms (go back to year you turned 65)

Here is what SSA will accept:

- Income tax form 1095 shows health insurance premiums paid.
- W-2s reflecting pre-tax medical contributions.
- Pay stubs that reflect health insurance premium deductions.
- Health insurance cards with a policy effective date.
- Explanations of benefits paid by the GHP or LGHP. (Group plan)
- Statements or receipts that reflect payment of health insurance premiums.

If you do not qualify under your own social security but you were married for 10 years to someone who does qualify. You must gather proof and set an appointment with your local social security office.

If you need help: **go to the local agent search** and we will be happy to assist you with this process.

Checklist for Online Medicare, Retirement, & Spouses Applications

The information below will help you gather the information you may need to create a *my* Social Security account and complete the online Medicare, Retirement, and Spouse's applications. We recommend you print this page to use while gathering your information.

Create a *my* Social Security Account

You are required to login to your existing *my* Social Security account, or attempt to create one. To create an account, we will ask you a series of identity questions for verification. You may want to have certain items on hand to be prepared for additional security questions, such as, but not limited to: **mobile phone (for the purpose of receiving texts and emails), credit card, W-2, and tax forms.**

File for Benefits Online – The Information You Need	*Medicare Only*	*Retirement & Spouses*
Date and Place of Birth If you were born outside the United States or its territories: • Name of your birth country at the time of your birth (it may have a different name now) • Permanent Resident Card number (if you are not a U.S citizen)	X	X
MEDICAID Number (State Health Insurance) - Start and End Dates	X	
Current Health Insurance • Employment start and end dates for the current employer (of you or your spouse) who provides your health insurance coverage through a Group Health Plan • Start and end dates for the Group Health Insurance provided by you (or your spouse's) current employer	X	
Marriage and Divorce • Name of current spouse • Name of prior spouse (if the marriage lasted more than 10 years or ended in death) • Spouse(s) date of birth and SSN (optional) • Beginning and ending dates of marriage(s) • Place of marriage(s) (city, state or country, if married outside the U.S.)		X
Names and Dates of Birth of Children Who: • Became disabled prior to age 22, or • Are under age 18 and are unmarried, or • Are aged 18 to 19 and still attending secondary school full time		X
U.S. Military Service • Type of duty and branch • Service period dates		X
Employer Details for Current Year and Prior 2 Years (not self-employment) • View your Social Security Statement online at ***www.socialsecurity.gov/myaccount*** • Employer name • Employment start and end dates		X
Self-Employment Details for Current Year and Prior 2 Years • View your Social Security Statement online at ***www.socialsecurity.gov/myaccount*** • Business type • Total net income		X
Direct Deposit - Domestic bank (USA) • Account type and number • Bank routing number **Direct Deposit** - International bank (non-USA) • International Direct Deposit (IDD) bank country • Bank name, bank code, and currency • Account type and number, branch/transit number		X

Form Approved
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Expires: 02/21

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)

( ) –

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

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.