PRIVACY ACT NOTICE

The Social Security Administration (SSA) is authorized to collect 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 SSA and the Centers for Medicare & Medicaid Services (CMS) to determine if you are entitled to supplementary medical insurance benefits. While completing this form is voluntary, failure to provide all or part of this information will result in your not being enrolled for medical insurance under Medicare. You should be aware that the information you furnish can be released by way of "routine uses" published in the Federal Register. Because they are too numerous to list here, SSA can furnish you with additional information upon request. You should also be aware that the information you provide on this form may be verified by way of a computer match (Pub. Law 100-503).

SPECIAL MESSAGE FOR INDIVIDUAL APPLYING FOR MEDICAL INSURANCE UNDER MEDICARE

This form is your application for the medical Insurance part of Medicare. It can be used either during your initial enrollment period, during any general enrollment period, or during a special enrollment period to which you **may** be entitled if you are covered under an employer's group health plan.

Your initial enrollment period lasts for 7 months. It begins 3 months before the month you reach age 65 (or 3 months before the 25th month you have received social security disability benefits) and it ends 3 months after you reach age 65 (or 3 months after the 25th month you received social security disability benefits). To have medical insurance start in the month you are 65 (or the 25th month of disability insurance benefits), you must sign up in the first 3 months of your initial enrollment period. If you sign up in any of the remaining 4 months, your medical insurance will start later.

If you do not file during your initial enrollment period, you can file any time after that during a general enrollment period which is the first 3 months of every year. If you sign up in a general enrollment period, your medical insurance begins July 1 of that year . However, when you file in a general enrollment period, your premium may be subject to a penalty increase. For each 12 month period elapsing between the end of your initial enrollment period and the general enrollment period in which you file, your premium will be increased 10 percent.

If you are age 65 or older and employed, or the spouse of an employed person, and are covered under an employer group health plan, you may be eligible to enroll during any of the 7 months after employment is terminated or, if earlier, after your employer group health plan coverage ends for any reason. Also, if you are under age 65, entitled to Medicare based on disability, and are covered under an employer's group health plan based on your own current employment or the current employment of your spouse, or are covered under a large group health plan based on your own current employment or the current employment of any family member, you may be eligible to enroll during a special 7-month enrollment period which begins when the employer group health plan coverage ends or the employment ends, whichever occurs first. Your medical insurance coverage will begin sooner under this special enrollment provision than it will if you delay enrollment until the following general enrollment period. Also, you may be eligible under this special provision for a reduction in the premium surchage or penalty that usually applies to people who delay their enrollment in medical insurance under Medicare. If you are covered under an employer's group health plan and think that you may be eligible for a special enrollment period, please discuss your enrollment eligibility with a representative at the Social Security office.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB No. 0938-0787

REQUEST FOR EMPLOYMENT INFORMATION

From: Social Security Administration Telephone No.

Employer's Name and Address

Date:

Employee's Name:

Employee's Social Security Number:

Claimant's Name:

Claim Number:

Dear Sir/Madam:

We need the following information regarding the above claimant. Please answer the questions below, sign and date this letter and return it in the enclosed envelope.

You may call _____ at the above telephone number if you have any questions.

Sincerely,

Office Manager

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1. Is (or was) the claimant covered under an Employer Group Health Plan? Yes _____ No _____

2. If Yes, give the original date the coverage mm/yyyy _____

3. Has the coverage ended? Yes _____ No _____

4. If Yes, give the date the coverage en mm/yyyy _____

From _____ To _____ Still employed _____
mm/dd/yyyy mm/dd/yyyy

Signature and Title of Company Official Date Telephone Number

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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 0938-0787. 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 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.

Form **CMS-L564** (4-2000)

FORM DOES NOT REQUIRE CLEARANCE
OF OFFICE OF MANAGEMENT AND BUDGET

APPLICATION FOR ENROLLMENT IN MEDICARE
THE MEDICAL INSURANCE PROGRAM

TID SMI

1. SOCIAL SECURITY CLAIM NUMBER

CAN ☐☐☐-☐☐-☐☐☐☐

2. FOR AGENCY USE ONLY

BIC ☐☐☐

3. DO YOU WISH TO ENROLL FOR MEDICAL INSURANCE UNDER MEDICARE?

DEC YES ☐

4. CLAIMANT'S NAME

CLN

Last name First name Middle initial

5. PRINT SOCIAL SECURITY NUMBER HOLDER'S NAME IF DIFFERENT FROM YOURS

6. MAILING ADDRESS (NUMBER AND STREET, P.O. BOX, OR ROUTE)

IF THIS IS A CHANGE OF ADDRESS, CHECK HERE ☐

7. CITY, STATE, AND ZIP CODE

8. TELEPHONE NUMBER

9. WRITTEN SIGNATURE (DO NOT PRINT)

SIGN → _____

10. DATE SIGNED

DOF __ __ / __ __ / __ __
MONTH DAY YEAR

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

11. SIGNATURE OF WITNESS

12. DATE SIGNED

13. ADDRESS OF WITNESS

14. REMARKS

TOA 1

TO: (Check one)

☐ (1) NEPSC ☐ (2) MATPSC ☐ (3) SEPSC ☐ (4) GLPSC ☐ (5) WNPSC ☐ (6) MAMPSC ☐ (7) ODO ☐ (8) DIO