Signing Up For Part A & B

You can sign up for Medicare A & B through Social Security in four ways.

- Telephone 1 (800) 772-1213 and provide supporting documents by mail or fax.

- In Person Appointment

  Social Security Office

  140 Union St, Lynn, MA 01901

  Phone: (866) 366-7792

  Fax: (833)-902-2508

- Online (create a my social security account) https://www.ssa.gov/benefits/medicare/ and provide supporting documents by upload, mail or fax.

- Paper Application with supporting documents by fax or mail.

Once you have your Medicare card, or Medicare part B effective date, our SHINE counselors will be happy to assist with enrolling into secondary plans one month prior to the Medicare effective date.

Form Approved
OMB No. 0938-1230
Expires: xx/xx

APPLICATION FOR PART A (HOSPITAL INSURANCE)

1. TELL US ABOUT YOURSELF: We need this information to find you in our records.

1a. Your Social Security Number (or your Medicare Number, if you already have Part B)
☐☐☐ / ☐☐ / ☐☐☐☐

1b. Your Name (Last Name, First Name, Middle Name)

1c. Name at Birth if different than item 1b

1d. Sex
☐ Male ☐ Female

1e. Date of Birth (MM/DD/YYYY)
☐☐ / ☐☐ / ☐☐☐☐

1f. State or Country of Birth (NO abbreviations)

1g. Mailing Address (Number and Street, P.O Box, or Route)

1h. Address of permanent residence, if different from your mailing address

1i. Phone Number
(☐☐☐) ☐☐☐ – ☐☐☐☐

2. TELL US ABOUT YOUR WORK HISTORY:

2a. How much were your total earnings last year? If none, write "NONE."

2b. How much do you expect your total earnings to be this year? If none, write "NONE."

2c. Did you work in the railroad industry after January 1, 1937?
☐ Yes ☐ No

3. TELL US ABOUT YOUR CITIZENSHIP:

3a. Are you a United States citizen? (If yes, go to item 4.) ☐ Yes ☐ No

3b. Are you lawfully present in the U.S.? (If no, go to item 4.)
☐ Yes ☐ No

3c. When did you become lawfully present in the U.S.? (MM/DD/YYYY)
☐☐ / ☐☐ / ☐☐☐☐

3d. Are you currently a resident of the U.S.? ☐ Yes ☐ No

3e. When did you become a resident of the U.S.? (MM/DD/YYYY)
☐☐ / ☐☐ / ☐☐☐☐

3f. Have you resided in the U.S. without a break for the past 5 years? ☐ Yes ☐ No

3g. Enter where you lived for the last 5 years and the dates you lived there.

Address	Started living there	Stopped living there
	☐☐ / ☐☐ / ☐☐☐☐	☐☐ / ☐☐ / ☐☐☐☐

3h. Have you been outside the U.S. in the last 5 years? ☐ Yes ☐ No

4. TELL US ABOUT YOUR MARITAL STATUS:

4a. Are you currently married? ☐ Yes ☐ No

4b. Spouse's name (last name, first name, middle name)

4c. Spouse's Date of Birth (MM/DD/YYYY)
☐☐ / ☐☐ / ☐☐☐☐

4d. Spouse's Social Security Number
☐☐☐ / ☐☐ / ☐☐☐☐

4e. Date of marriage (MM/DD/YYYY)
☐☐ / ☐☐ / ☐☐☐☐

4f. If you are not married now, did you have a former marriage that lasted 10 or more years OR ended in death?
(If no, go to item 10.) ☐ Yes ☐ No

4g. Name of former spouse (last name, first name, middle name)

4h. Former spouse's date of birth (MM/DD/YYYY)
☐☐ / ☐☐ / ☐☐☐☐

4i. Spouse's Social Security Number
☐☐☐ / ☐☐ / ☐☐☐☐

4j. Date of former marriage (MM/DD/YYYY)
☐☐ / ☐☐ / ☐☐☐☐

4k. Date former marriage ended (MM/DD/YYYY)
☐☐ / ☐☐ / ☐☐☐☐

4l Date of former spouse's death, if deceased (MM/DD/YYYY)
☐☐ / ☐☐ / ☐☐☐☐

4m. Do you have another marriage that lasted 10 years or ended in death? ☐ Yes ☐ No

5. ENROLLMENT IN PREMIUM PART A AND PART B:

5a. If you have to pay a premium for Part A, do you still want to get Part A? (If "Yes", You must also sign up for Part B, and you have to pay monthly premiums.) ☐ Yes ☐ No

5b. Do you want to sign up for Part B? (You pay a monthly premium for Part B.) ☐ Yes ☐ No

6. TELL US ABOUT YOUR CURRENT OR PRIOR HEALTH COVERAGE AND BENEFITS:

We need this information to determine when you can sign up and your premiums.

6a. Do you have Medicaid? (People with Medicaid can **get help paying their premiums**. If yes, go to item 7.) ☐ Yes ☐ No

6b. Do you currently have (or did you have) coverage through an employer or union group health plan? (If yes, complete item 6d.) ☐ Yes ☐ No	6c. Are you currently (or were you) an international volunteer for a non-profit organization and have or had health coverage provided to you? (If yes, complete item 6d.) ☐ Yes ☐ No

6d. Enter dates of employment (or volunteer work) and health coverage (Enter all dates as MM/DD/YYYY)

Dates you (or your spouse) worked for employer that provided health coverage:	Dates of health coverage from employer (or non-profit organization):	Dates you worked as a volunteer outside the U.S.:
Start Date: ☐☐/☐☐/☐☐☐☐	Start Date: ☐☐/☐☐/☐☐☐☐	Start Date: ☐☐/☐☐/☐☐☐☐
Ending Date: ☐☐/☐☐/☐☐☐☐	Ending Date: ☐☐/☐☐/☐☐☐☐	Ending Date: ☐☐/☐☐/☐☐☐☐
Not ended ☐	Not ended ☐	Not ended ☐

6e. Are you (or your spouse) currently getting retirement benefits from the Office of Personnel Management (OPM)? (If no, go to item 7.) ☐ Yes ☐ No

6f. Your OPM retirement claim number	6g. Your spouse's OPM retirement claim number

6h. Do you want to have your Part B premiums deducted from your spouse's retirement benefits? (See instructions on page 8 before you answer.) ☐ Yes ☐ No

7. SIGN YOUR APPLICATION:

7a. If you are completing this application for someone else, what's your name and your relationship to the person applying?

NA

By signing this application, I understand that the information I entered will be used to process my application for Medicare. I understand that if I intentionally provide false information on this form, it is a crime punishable under Federal law by fine, imprisonment, or both. I declare under penalty of perjury that the information I entered is true and correct to the best of my knowledge.

7b. Written signature (Do not print)	7c. Date Signed ☐☐/☐☐/☐☐☐☐

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

7d. Name of witness (first and last name)

NA

7e. Signature of witness	7f. Date Signed ☐☐/☐☐/☐☐☐☐
NA	

7g. Extra Space for items 3g and 6d, if needed

I know that anyone who makes or causes to be made a false statement or representation of material fact in an application or for use in determining a right to payment under the Social Security Act commits a crime punishable under Federal law by fine, imprisonment or both. I affirm that all information I have given in this document is true.

Signature of Applicant	Date Signed ☐☐/☐☐/☐☐☐☐
Printed Name of Witness	
Signature of Witness	Date Signed ☐☐/☐☐/☐☐☐☐