Form Approved
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APPLICATION FOR MEDICARE PART A AND PART B – SPECIAL ENROLLMENT PERIOD (EXCEPTIONAL CONDITIONS)

WHAT IS THE PURPOSE OF THIS FORM?

If, due to an exceptional condition, you didn't sign up for Medicare Premium Part A or Part B during your Initial Enrollment Period (IEP), General Enrollment Period (GEP), or a Special Enrollment Period (SEP) you were previously eligible for, you can sign up without a late enrollment penalty during a SEP for Exceptional Conditions. If you think that you may be eligible for a SEP for Exceptional Conditions, please contact Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.

NOTE: Your IEP lasts for 7 months. It begins 3 months before your 65th birthday (or 25th month of disability) and ends 3 months after you reach 65 (or 3 months after the 25th month of disability). The GEP is from January 1 – March 31 each year. The most common SEPs apply to the working aged, disabled, and international volunteers.

WHAT INFORMATION DO YOU NEED TO COMPLETE THIS FORM?

You will need:

- Your Medicare Number or Social Security number (SSN)
- Your current address and phone number
- Qualifying documentation of eligibility for the SEP

HOW DO YOU SUBMIT THE FORM?

Complete and sign page 4 of the form and send it to your local Social Security field office.

HOW DO YOU GET HELP WITH THIS FORM?

- Call Social Security at 1-800-772-1213. TTY users can call 1-800-325-0778.
- Contact your local field office. Find an office near you at **www.ssa.gov/locator**.
- **En español:** Llame a SSA gratis al 1-800-772-1213 y oprima el 7 si desea el servicio en español y espere a que le atienda un agente.

PRA Disclosure Statement: 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 0938-1426. 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.

Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact the Social Security Administration at 1-800-772-1213. TTY users can call 1-800-325-0778.

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

1. Your Social Security Number (or your Medicare Number, if you already have Medicare Part A)

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

3. Name at Birth if different than item 2

4. Sex
○ Male ○ Female

5. Date of Birth (mm/dd/yyyy)
☐☐/☐☐/☐☐☐☐

6. State or Country of Birth (NO abbreviations)

7. Mailing Address (Number and Street, P.O. Box or Route, City, State, Zip)

8. Address of permanent residence, if different from your mailing address (Number and Street, P.O. Box or Route, City, State, Zip)

9. Phone Number
(☐☐☐) ☐☐☐ – ☐☐☐☐

10. Do you wish to sign up for Medicare Part B (Medical Insurance)?
○ Yes ○ No

SPECIAL ENROLLMENT PERIOD (EXCEPTIONAL CONDITIONS):

Based on the descriptions below, please select the SEP that you believe best fits your situation. If none apply, please contact the Social Security Administration (SSA) to see if there are other available options.

☐ **SEP for Individuals Impacted by an Emergency or Natural Disaster**

Dates of the declared emergency (The declaration must be on or after January 1, 2023):

Start Date: ☐☐/☐☐☐☐ Ending Date: ☐☐/☐☐☐☐

Optional Description of Emergency (e.g. "Hurricane Ian," "California Fairview Fire"): ______________________

Select this SEP if:

- You (or your authorized representative, legal guardian, or person who makes healthcare decisions on your behalf) reside (or resided) in an area for which a federal, state or local government entity declared a disaster or other emergency
- You were in your IEP, GEP, or another SEP and were not able to enroll in Medicare as a result of a disaster or other emergency declared by a federal, state or local government entity

The SEP begins at the start of the emergency or disaster, and ends 6 months after the end date identified in the declaration.

☐ **SEP for Group Health Plan (GHP) or Employer Misrepresentation**

Select this SEP if:

- On or after January 1, 2023 you did not enroll in Part B during your IEP, GEP, or another SEP due to misinformation provided by your employer, GHP, or agent or broker of a health plan.

Please attach documented evidence of the misinformation that is directly from your employer or GHP. The evidence shows that the misinformation was provided prior to the end of your IEP, GEP, or another SEP. If you do not have documented evidence, you will need to provide a written attestation outlining the misinterpretation. See attachment 1 "Attestation."

This SEP begins the day that you notify SSA of the misrepresentation and ends 6 months later.

☐ SEP for Termination of Medicaid Eligibility

Select this SEP if you have lost or will lose Medicaid coverage on or after January 1, 2023.

The SEP starts when you are notified of the loss of Medicaid coverage and ends 6 months after Medicaid ends.

Coverage Effective Date Options: Choose ***one*** of the following options. If you leave this section blank, your coverage effective date will be option 1.

◯ **Option 1:** Your coverage will begin the first day of the month following the month of enrollment. Medicare will not cover items or services prior to that date.

◯ **Option 2:** Your coverage will begin the first day of the month in which you lost Medicaid coverage. You will need to pay premiums back to the month you lost Medicaid coverage. Coverage can begin no earlier than January 1, 2023.

Please attach a document or copy of a document from your state or health plan showing the date your Medicaid coverage will end or has ended. If you do not have documents, SSA will contact your state to confirm your loss of Medicaid coverage.

☐ SEP for Formerly Incarcerated Individuals

Date of Incarceration: ☐☐ / ☐☐☐☐

Date of Release (on or after January 1, 2023): ☐☐ / ☐☐☐☐

Select this SEP if you were released within the last 12 months and **ANY** of the following apply:

- Your Medicare was terminated due to non-payment of premiums while you were incarcerated* (meaning the individual is in custody of penal authorities as defined in 42 CFR §411.4).
- You voluntarily terminated your coverage while incarcerated.
- You became eligible for Premium Part A or Part B, while incarcerated.

* Individuals who are in custody include, but are not limited to, individuals who are under arrest, incarcerated, imprisoned, escaped from confinement, under supervised release, on medical furlough, required to reside in mental health facilities, required to reside in halfway houses, required to live under home detention, or confined completely or partially in any way under a penal statute or rule.

The SEP starts the day you are released from incarceration and ends the last day of the 12th month after the month in which you were released.

Coverage Effective Date Options: Choose ***one*** of the following options. If you leave this section blank, your coverage effective date will be option 1.

◯ **Option 1:** Your coverage will begin the first day of the month following the month of enrollment.

◯ **Option 2:** Your coverage will begin retroactively to the first day of the month of your release from incarceration, not to exceed 6 months. You will need to pay premiums back to the month of your release. Coverage can begin no earlier than January 1, 2023.

☐ SEP for Other Exceptional Conditions

Select this SEP if you have a different exceptional condition that occurred on or after January 1, 2023 and is not listed above. You must have proof of the following:

- You experienced circumstances outside of your control that caused you to miss your IEP, GEP, or another SEP.

Please provide a written attestation outlining the condition causing you to miss an enrollment period. See attachment 1 “Attestation.”

The SEP starts on the day that you notify SSA and the duration is determined on a case-by-case basis, but not less than 6 months from the start date.

SIGN YOUR APPLICATION

I understand that anyone who, knowingly and willfully — (1) falsifies, conceals, or covers up by any trick, scheme, or device a material fact; or (2) makes any materially false, fictitious, or fraudulent statements or representations, or makes or uses any materially false writing or document knowing the same to contain any materially false, fictitious, or fraudulent statement or entry, in connection with the delivery of or payment for health care benefits, items, or services, shall be fined or imprisoned not more than 5 years, or both.[1]

Signature (Do not print)	Date Signed __/__/____

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

Name of Witness (First and Last Name) (Printed)	
Witness (Signature)	Date Signed __/__/____
Witness Address	

[1] 18 U.S. Code § 1035 - False statements relating to health care matters

(a) Whoever, in any matter involving a health care benefit program, knowingly and willfully—

(1) falsifies, conceals, or covers up by any trick, scheme, or device a material fact; or

(2) makes any materially false, fictitious, or fraudulent statements or representations, or makes or uses any materially false writing or document knowing the same to contain any materially false, fictitious, or fraudulent statement or entry, in connection with the delivery of or payment for health care benefits, items, or services, shall be fined under this title or imprisoned not more than 5 years, or both.

(b) As used in this section, the term "health care benefit program" has the meaning given such term in section 24(b) of this title.

Privacy Act Statement: Sections 226 and 1818 of the Social Security Act, as amended, allow SSA to collect this information. Furnishing this information is voluntary. However, failing to provide all or part of the information may prevent an accurate and timely decision on any claim filed for medical insurance and/or hospital insurance.

We will use the information you provide to determine your eligibility for benefits. We may also share the information for the following purposes, called routine uses:

- To Federal, State, or local agencies (or agents on their behalf) for administering income maintenance or health maintenance programs (including programs under the Social Security Act). Such disclosure include, but are not limited to, release of information to:
  a. Railroad Retirement Board for administering provision of the Railroad Retirement Act relating to railroad employment; for administering the Railroad Unemployment Insurance Act and for administering provisions of the Social Security Act relating to railroad employment;
  b. Department of Veterans Affairs for administering 38 U.S.C. 1312, and upon request, for determining eligibility for, or amount of, veterans benefits or verifying other information with respect thereto pursuant to 38 U.S.C. 5106;
  c. State welfare departments for administering sections 205(c)(2)(B)(i)(II) and 402(a)(25) of the Social Security Act requiring information about assigned Social Security numbers for Temporary Assistance for Needy Families (TANF) program purposes and for determining a recipient's eligibility under the TANF program; and
  d. State agencies for administering the Medicaid program.
- To contractors and other Federal agencies, as necessary, for the purpose of assisting the Social Security Administration (SSA) in the efficient administration of its programs. We will disclose information under the routine use only in situations in which SSA may enter into a contractual or similar agreement with a third party to assist in accomplishing an agency function relating to this system of records.
- In addition, we may share this information in accordance with the Privacy Act and other Federal laws. For example, where authorized, we may use and disclose this information in computer matching programs, in which our records are compared with other records to establish or verify a person's eligibility for Federal benefit programs and for repayment of incorrect or delinquent debts under these programs.

A list of additional routine uses is available in our Privacy Act System of Records Notice (SORN) 60-0090, entitled Master Beneficiary Record, as published in the Federal Register (FR) on January 11, 2006, at 71 FR 1826. Additional information, and a full listing of all of our SORNs, is available on our website at **www.ssa.gov/privacy**.

SPECIAL ENROLLMENT PERIOD FOR EXCEPTIONAL CONDITIONS ATTESTATION (ATTACHMENT 1)

Please use this attachment to provide additional information related to your exceptional condition. We will use the information you provide to determine your eligibility for this SEP.

Your Name	Your SSN or Medicare Number
Date(s) of the incident, if unknown please provide an approximation	Missed Enrollment Period(s) Check all that apply ☐ IEP ☐ GEP ☐ Other SEP

GHP OR EMPLOYER MISREPRESENTATION:

Type of entity that provided the misinformation (Check One) ◯ Employer ◯ GHP ◯ Agent or Broker

Name of the entity that provided the misinformation

Name and title of entity representative (if known)

SEP FOR OTHER EXCEPTIONAL CONDITIONS:

Name and Contact information for additional parties involved (if applicable)

ATTESTATION

I understand that anyone who, knowingly and willfully — (1) falsifies, conceals, or covers up by any trick, scheme, or device a material fact; or (2) makes any materially false, fictitious, or fraudulent statements or representations, or makes or uses any materially false writing or document knowing the same to contain any materially false, fictitious, or fraudulent statement or entry, in connection with the delivery of or payment for health care benefits, items, or services, shall be fined or imprisoned not more than 5 years, or both.

Signature (Do not print)	Date Signed ☐☐/☐☐/☐☐☐☐

Please use this page to describe in detail what exceptional condition was and how it caused you to miss your enrollment period. If any additional parties were involved, please explain how they were involved. If you run out of space, please attach a separate sheet to this form.

☐ Check here if an additional sheet is attached.