**How to complete CMS-40B**

Introduction: How to Complete Form CMS-40B for Medicare Enrollment
This guide is designed to help you navigate the process of filling out Form CMS-40B, which is used to enroll in Medicare Part B (Medical Insurance). Whether you're signing up during your Initial Enrollment Period, using a Special Enrollment Period, or enrolling during the General Enrollment Period, this document will provide step-by-step instructions to ensure you complete the form accurately.

Who should use this guide:

- Individuals turning 65 who need to enroll in Medicare Part B
- People over 65 who delayed Part B enrollment due to other coverage and are now ready to enroll
- Those who missed their Initial Enrollment Period and need to use the General Enrollment Period

By following these instructions, you'll be able to navigate the enrollment process with confidence, avoiding common pitfalls and potential penalties. Remember, enrolling in Medicare at the right time is crucial for ensuring continuous health coverage and avoiding late enrollment penalties.

Let's begin with understanding the different enrollment periods and how to complete Form CMS-40B for each scenario.

You can access the form at https://www.cms.gov/cms40b-application-enrollment-part-b

This form is used for 3 different enrollment periods:

- IEP – Initial Enrollment Period
- SEP – Special Enrollment Period
- GEP – General Enrollment Period

We'll Start the with IEP.

# IEP - Initial Enrollment Period

The initial enrollment period is 3 months before you turn 65, the month you turn 65, and the 3 months after you turn 65.

| Month 1 | Months 2 | Month 3 | Month 4 | Month 5 | Month 6 | Month 7 |
|---|---|---|---|---|---|---|
| | | | **Month you turn 65** | | | |

**You do NOT need form 40B if you enrolled in both Parts A & B during your online application for Medicare.**

**If you do NOT already have Part A do NOT complete this form. Contact Social Security if you want to apply for Medicare for the first time.**

You would only use form 40B if you enrolled online for Part A **only**, but then decided later to add Part B while still within your 7-month time frame of the IEP.

You must turn the form into your local Social Security office. An appointment is not needed. Just be a walk-in.

## APPLICATION FOR ENROLLMENT IN MEDICARE PART B (MEDICAL INSURANCE)

1. Your Medicare Number
2. Your Name (Last Name, First Name, Middle Name)
3. Mailing Address (Number and Street, PO Box, or Route)
4. City — State — Zip Code
5. Phone Number (Including Area Code)

1. This is your Medicare number. If you already know your Medicare number because you received your red, white, and blue Medicare card or know it from your Social Security dashboard, enter it here. If you don't have your Medicare number but know you enrolled in Part A, enter your Social Security number.
2. This is your full legal name, Last, First, and Middle name.
3. This is the street address where you received the mail.
4. Your current City, State, and Zip code
5. This is your current phone number in case they need to contact you about your enrollment application.

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

7a. Do you currently have (or did you have) coverage through an employer or union group health plan? (If yes, complete 7c.) ☐ YES ☐ NO

7b. 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 7c.) ☐ YES ☐ NO

7c. Enter dates of employment (or volunteer work) and health coverage below. (Enter all dates as MM/YYYY)

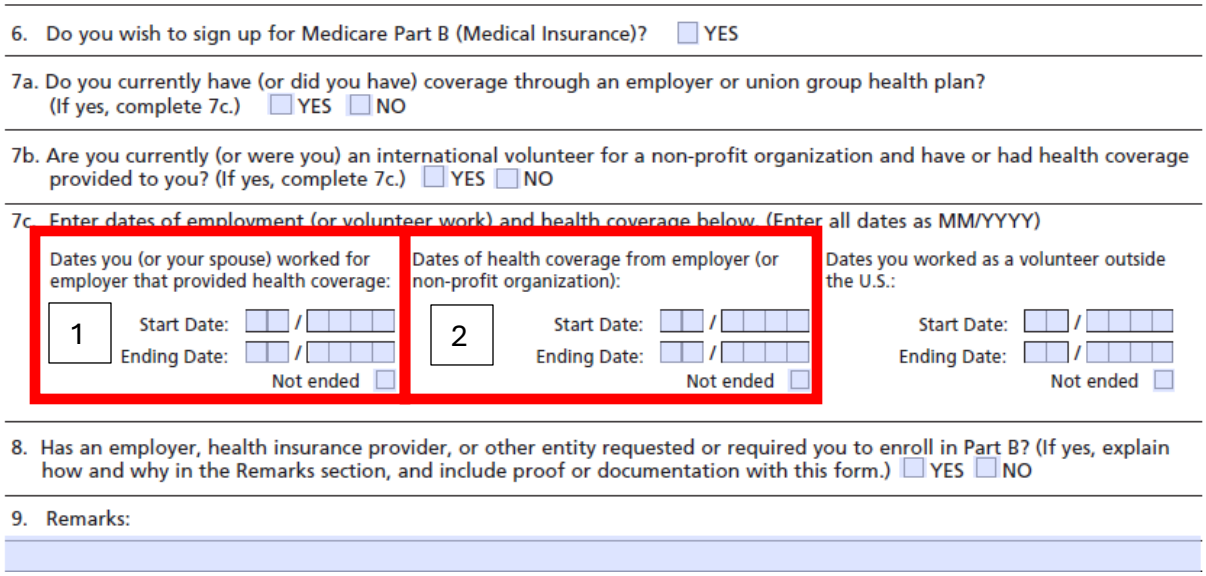
| Dates you (or your spouse) worked for employer that provided health coverage: | Dates of health coverage from employer (or non-profit organization): | Dates you worked as a volunteer outside the U.S.: |
|---|---|---|
| Start Date: / | Start Date: / | Start Date: / |
| Ending Date: / | Ending Date: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

8. Has an employer, health insurance provider, or other entity requested or required you to enroll in Part B? (If yes, explain how and why in the Remarks section, and include proof or documentation with this form.) ☐ YES ☐ NO

9. Remarks:

6. This is asking you if you want to sign up for Part B. Click on the check box "*Yes*".
7. a. 7a. asks if you currently have or previously had group health insurance through an employer or union during your seven-month initial enrollment period, it doesn't really matter, but you'll want to go ahead and answer the question regarding employer health insurance you've had since becoming eligible for Medicare, whether that's because you turned 65 or earlier due to disability. If you don't have group health insurance through your employment or your spouse's employment, then answer "NO" and jump down to #8, but if you are currently covered in a

group health plan or were covered since becoming Medicare eligible, answer "YES" and jump to 7c.


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

7a. Do you currently have (or did you have) coverage through an employer or union group health plan? (If yes, complete 7c.) ☐ YES ☐ NO

7b. 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 7c.) ☐ YES ☐ NO

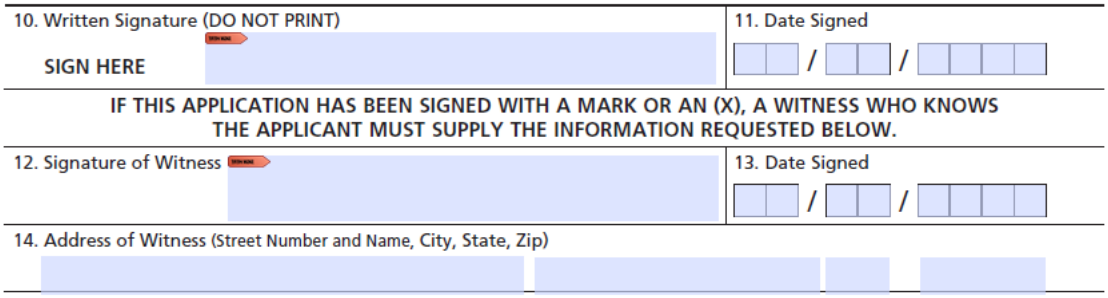
7c. Enter dates of employment (or volunteer work) and health coverage below. (Enter all dates as MM/YYYY)

| 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.: |
|---|---|---|
| 1 Start Date: ☐☐ / ☐☐☐☐ | 2 Start Date: ☐☐ / ☐☐☐☐ | Start Date: ☐☐ / ☐☐☐☐ |
| Ending Date: ☐☐ / ☐☐☐☐ | Ending Date: ☐☐ / ☐☐☐☐ | Ending Date: ☐☐ / ☐☐☐☐ |
| Not ended ☐ | Not ended ☐ | Not ended ☐ |

8. Has an employer, health insurance provider, or other entity requested or required you to enroll in Part B? (If yes, explain how and why in the Remarks section, and include proof or documentation with this form.) ☐ YES ☐ NO

9. Remarks:

7. b. 7b is only for those covered in a group health plan through a nonprofit organization as an international volunteer. Ignore it if it doesn't apply to you.
7. c. 7c. You need to complete two parts. The date range you or your spouse worked at the employer who provided the health insurance (1), and the date range you, the person applying for Medicare Part B, were covered on that employer health plan (2). Since we're talking about enrolling in Part B during your initial enrollment period, don't agonize over these dates. Just put something in that makes sense. Select a start date for sure, and add an end date if the employment and or insurance coverage has already ended, but if employment or coverage has not ended at this very moment, leave the end date blank and check the box that says, "*Not end*." These dates are more important when doing a special enrollment period (SEP) application after your initial enrollment period has ended.
8. This is likely a "*NO*" answer for most people. It asks if an employer health insurance provider or other entity is requiring you to enroll in Part B, i.e. If you work for a small employer with under 20 employees. In that scenario, you do need Medicare parts A&B as Medicare is primary coverage, and the employer health plan would be secondary if you stay on the employer plan.
9. #9 is a remarks section where you can add a note if necessary. if you answered "*NO*" to #8, then you don't need to add anything here, but if you answered "*YES*" to #8, then they want a brief description in this section.




Numbers 10 and 11 are for your signature and date. You do not need a witness signature for any of the situations covered in this document.

Now that the form is ready, when will Part B start? Here's how it works during your initial enrollment period.

| If you sign up in this month of your IEP | Your Part B starts |
|---|---|
| Month 1, 2, or 3 | 1st of your birthday month. |
| 4, 5, 6, or 7 | 1st of the next month |

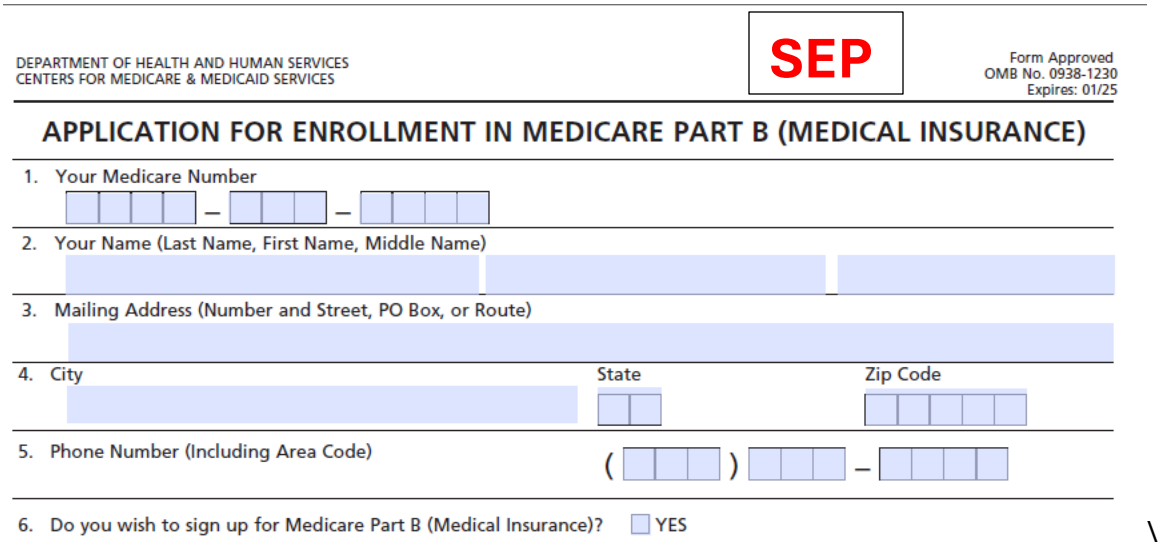
| Month 1 | Months 2 | Month 3 | Month 4 | Month 5 | Month 6 | Month 7 | Month 8 |
|---|---|---|---|---|---|---|---|
| | | | Month you turn 65 | | | | |

If you submit form 40B in months 1, 2, or 3, Part B will start the first of month 4, which is the first of your birthday. If you submit in months 4, 5, 6, or 7, Part B will start the 1st of the month immediately following that submission. This is the new process starting with people who have a Medicare eligibility date of January 2023 and after.

**Note** if your birthday is the 1st of the month, your eligibility date is one month before your birthday month. The complete form can now be submitted to Social Security during your initial enrollment.

# SEP – Special Enrollment Period

This would only be for when you're enrolling in Part B after your initial enrollment period has ended and you're coming off a group health plan through your employer. More specifically, it needs to be done while covered on that group health plan based on current employment, either through you or your spouse or during the 8 months immediately after separating service from the employer who provided that health insurance. You will not be penalized for enrolling late if you fall under these scenarios. When you're within three months of your desired Part B start date, submit the form to your local SSA office.



DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

SEP

Form Approved
OMB No. 0938-1230
Expires: 01/25

**APPLICATION FOR ENROLLMENT IN MEDICARE PART B (MEDICAL INSURANCE)**

1. Your Medicare Number
2. Your Name (Last Name, First Name, Middle Name)
3. Mailing Address (Number and Street, PO Box, or Route)
4. City State Zip Code
5. Phone Number (Including Area Code)
6. Do you wish to sign up for Medicare Part B (Medical Insurance)? YES

At the top, write in SEP. This note isn't truly necessary, but we find it helpful because it makes it very clear to the SSA Rep handling your application what you're doing as a Special Enrollment Period application.

1. This is your Medicare number. If you already know your Medicare number because you received your red, white, and blue Medicare card or know it from your Social Security dashboard, enter it here. If you don't have your Medicare number but know you enrolled in Part A, enter your Social Security number.
2. This is your full legal name, Last, First, and Middle name.
3. This is the street address where you received the mail.
4. Your current City, State, and Zip code
5. This is your current phone number in case they need to contact you about your enrollment application.
6. This is asking you if you want to sign up for Part B. Click on the check box "*Yes*".

7a. Do you currently have (or did you have) coverage through an employer or union group health plan? (If yes, complete 7c.) ☐ YES ☐ NO

7b. 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 7c.) ☐ YES ☐ NO

7c. Enter dates of employment (or volunteer work) and health coverage below. (Enter all dates as MM/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 ☐ |

8. Has an employer, health insurance provider, or other entity requested or required you to enroll in Part B? (If yes, explain how and why in the Remarks section, and include proof or documentation with this form.) ☐ YES ☐ NO

9. Remarks:

I would like my Part B to begin _____ 1st, 20___

| 10. Written Signature (DO NOT PRINT) SIGN HERE | 11. Date Signed ☐☐ / ☐☐ / ☐☐☐☐ |
|---|---|

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

| 12. Signature of Witness | 13. Date Signed ☐☐ / ☐☐ / ☐☐☐☐ |
|---|---|

14. Address of Witness (Street Number and Name, City, State, Zip)

7. a. is "*YES*," so check that box.
7. b. 7b is only for those covered in a group health plan through a nonprofit organization as an international volunteer. Ignore it if it doesn't apply to you.
7. c. It's important to get the dates as correct as possible in 7c, as SSA uses the information to confirm that you had creditable medical coverage through active employment since turning 65. This will enable you to avoid a late enrollment penalty for Part B.
8. This is most likely "*NO,*" as this scenario is typically for someone who delayed Part B because they didn't need it while on a group health plan through a large employer.
9. Enter in the remarks when you want your Part B to start. You have the option of choosing a date 1, 2, or 3 months in the future. Always a first-of-the-month start date.

Of course, sign and date numbers 10 and 11. You do not need a witness signature for any of the situations covered in this document (12, 13, 14).

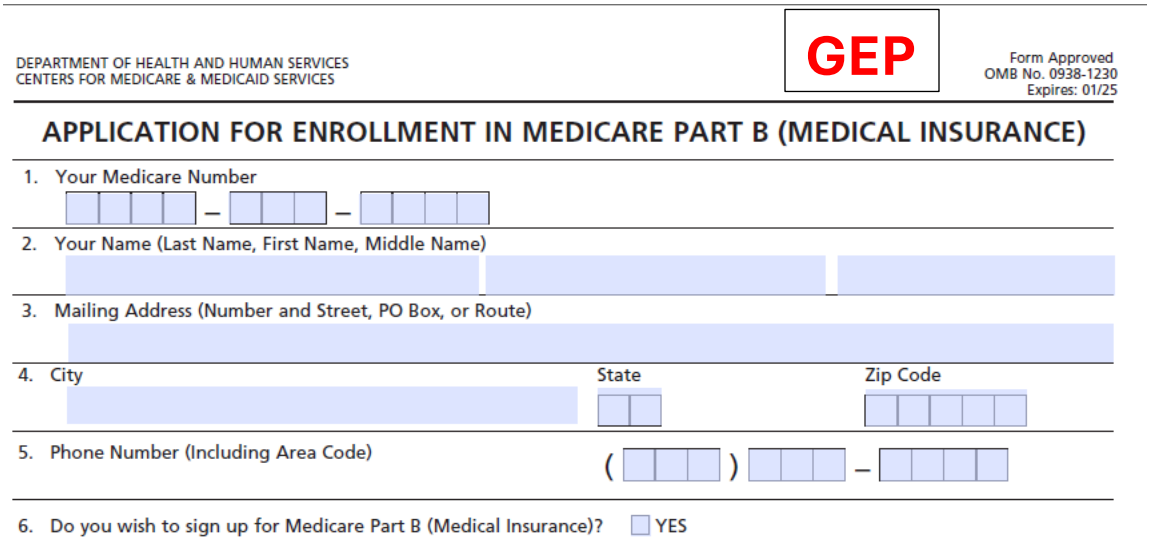
Now the form is complete, but it's not the only form you need to submit for an SEP application. You'll need to submit a CMS-L564 form as well. You can find instructions for this form on our site as well.

# GEP – General Enrollment Period

The General Enrollment Period spans January 1st through March 31st each year. This is for the people who didn't enroll in Part B during their initial enrollment period and also didn't use their special enrollment period because they failed to submit the necessary paperwork within eight months after separating service from their employer. These individuals must turn in a completed form 40B to their local SSA office in January, February, or March. The coverage start date will be the 1st of the month immediately after submitting. i.e.

- If you submit in January, coverage will begin in February,
- If you submitted February, coverage will begin in March and finally
- If you submit in March, coverage will begin in April

Completing the form, in this scenario, is almost the same as the initial enrollment period.



DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

GEP

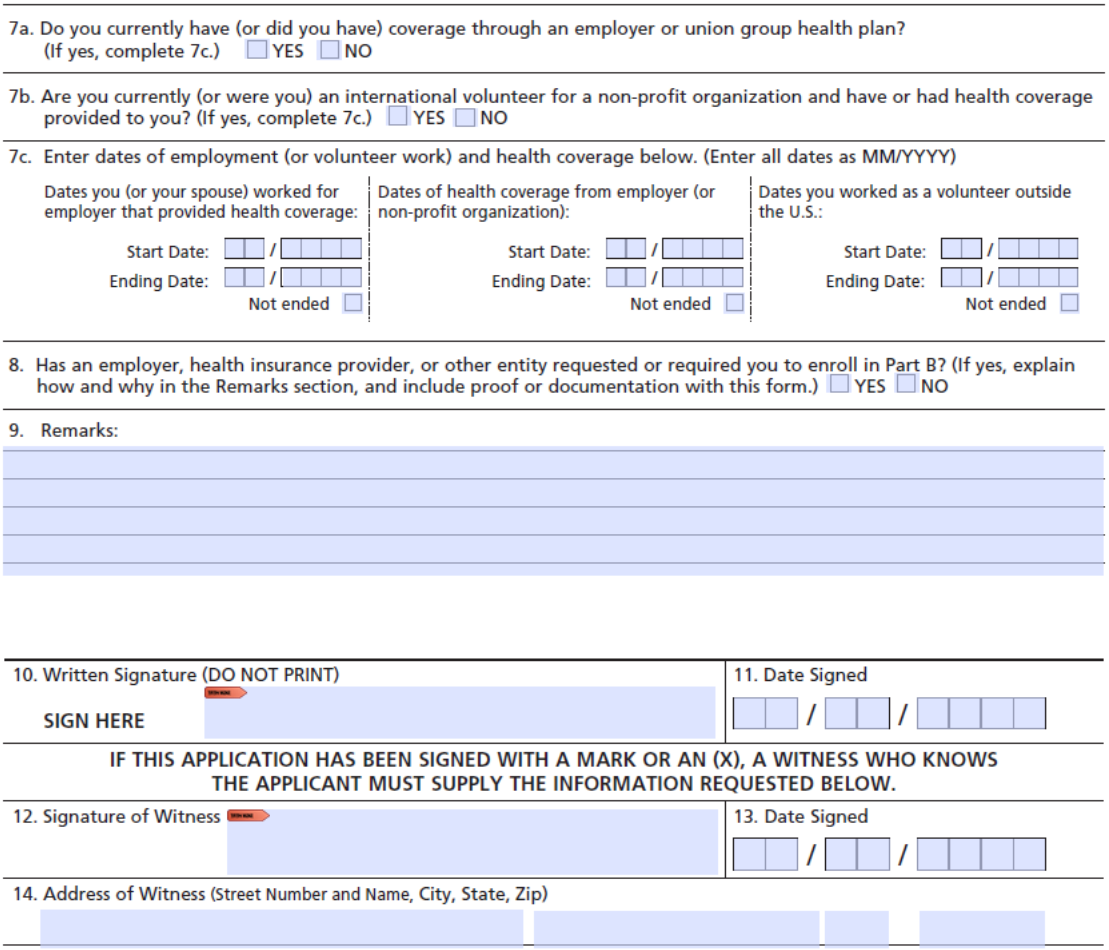
Form Approved
OMB No. 0938-1230
Expires: 01/25

**APPLICATION FOR ENROLLMENT IN MEDICARE PART B (MEDICAL INSURANCE)**

1. Your Medicare Number
2. Your Name (Last Name, First Name, Middle Name)
3. Mailing Address (Number and Street, PO Box, or Route)
4. City — State — Zip Code
5. Phone Number (Including Area Code)
6. Do you wish to sign up for Medicare Part B (Medical Insurance)? YES

At the top add GEP, making it clear to the SSA Rep that you understand this will be a GEP enrollment.

1. This is your Medicare number. If you already know your Medicare number because you received your red, white, and blue Medicare card or know it from your Social Security dashboard, enter it here. If you don't have your Medicare number but know you enrolled in Part A, enter your Social Security number.
2. This is your full legal name, Last, First, and Middle name.
3. This is the street address where you received the mail.
4. Your current City, State, and Zip code
5. This is your current phone number if they need to contact you about your enrollment application.
6. This is asking you if you want to sign up for Part B. Click on the check box "*Yes*".


7a. Do you currently have (or did you have) coverage through an employer or union group health plan? (If yes, complete 7c.) ☐ YES ☐ NO

7b. 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 7c.) ☐ YES ☐ NO

7c. Enter dates of employment (or volunteer work) and health coverage below. (Enter all dates as MM/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 ☐ |

8. Has an employer, health insurance provider, or other entity requested or required you to enroll in Part B? (If yes, explain how and why in the Remarks section, and include proof or documentation with this form.) ☐ YES ☐ NO

9. Remarks:

10. Written Signature (DO NOT PRINT) — SIGN HERE

11. Date Signed ☐☐ / ☐☐ / ☐☐☐☐

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

12. Signature of Witness

13. Date Signed ☐☐ / ☐☐ / ☐☐☐☐

14. Address of Witness (Street Number and Name, City, State, Zip)

7. a. Because this is a GP enrollment, 7a is likely "*NO*," but if you did have employer group health coverage for at least a period of time after turning 65, you want to answer yes and enter those dates in #7c and add a note in the #9 remarks section to explain. Otherwise, 7a is "*NO*".
7. b. 7b is only for those covered in a group health plan through a nonprofit organization as an international volunteer. Ignore it if it doesn't apply to you.
7. c. As noted in #7a above, if you did have employer group health coverage for at least a period of time after turning 65, you want to answer yes and enter those dates.
8. In this scenario, #8 will be "*NO*".
9. The Remarks section isn't always needed for a GP enrollment, but you certainly can add a note if you feel it's helpful.

Of course, sign and date numbers 10 and 11, then you're ready to submit to your local SSA office.