810.5 General Health Insurance Eligibility Requirements

Individuals may participate in the Medicare program if they meet the requirements in one of the following categories.

810.5.1 Regular Insured Provision

Individuals who are residents of the United States are eligible for hospital and medical insurance if they have attained age 65 and are either entitled to a monthly retirement-survivor insurance (RSI) benefit or are not receiving benefits, but would qualify if they filed an application. In addition, an individual must not be convicted of certain crimes against the U.S. to be eligible for medical insurance.

810.5.2 Disability Provision

Individuals who are residents of the United States, under age 65, and have been entitled or deemed entitled to a disability benefit under the Social Security Act for 24 months are eligible for hospital and medical insurance. In addition, an individual must not have been convicted of certain crimes against the U.S. to be eligible for medical insurance.

Note: Effective July 1, 2001, a disability beneficiary diagnosed with Amyotrophic Lateral Sclerosis (ALS) is not required to serve the 24-month waiting period for Medicare coverage. See section 810.15.

A disabled individual who is entitled to worker's compensation or public disability benefits may have medical insurance coverage based on this entitlement. Although such coverage does not affect an employee's eligibility for Medicare, the Part B Medicare contractor is notified of such additional coverage to prevent duplicate reimbursement.

810.5.3 Transitionally Insured Provision

Individuals who have attained age 65 and are not regularly insured are eligible for hospital and medical insurance if they are U.S. citizens or lawfully admitted aliens and U.S. residents. In addition, if age 65 was attained after 1967, an individual must have not less than three quarters of coverage, whenever acquired, for each calendar year after 1966 and before the year age 65 was attained.

The Social Security Administration (SSA) is responsible for coverage under this provision.

810.5.4 Uninsured Provision

Individuals who have attained age 65 and are not regularly or deemed insured are eligible for medical insurance if they are U.S. citizens or lawfully admitted aliens and U.S. residents. Such individuals may also qualify for hospital insurance, called Premium HI, if they enroll or are already enrolled under Part B-SMI. In addition, to be eligible for medical insurance, an individual must not have been convicted of certain crimes against the U.S.; to be eligible for Premium HI, an individual must already be enrolled for medical insurance or be eligible and file for medical insurance.

The enrollment periods for medical insurance apply to Premium HI. Eligibility, entitlement and collection of premiums for hospital insurance and medical insurance under this provision are made by SSA.

810.5.5 End Stage Renal Disease (ESRD) Provision

Individuals of any age with irreversible damage to their kidneys requiring dialysis or a kidney transplant may qualify for hospital and medical insurance. Such individuals must be entitled to, or be the spouse or dependent child of someone entitled to a monthly benefit under title II of the Social Security Act or under the Railroad Retirement Act, or be fully or currently insured.

If the above requirements for entitlement are met, coverage based on end-stage renal disease (ESRD) begins the earlier of the first day of:

1. the 3rd month after the month in which dialysis begins (This is the most common situation.); or

2. the month dialysis begins, if the individual begins a self-dialysis training program in a renal Medicare-approved center before the fourth month of dialysis, has completed or is expected to complete the program, and can reasonably be expected to self-dialyze after the training, or

3. the month dialysis is resumed following a previously terminated period of Medicare coverage based on ESRD, or

4. the month of kidney transplant surgery; or

5. the month a decision of transplant surgery is made, provided:

    a. the individual is an inpatient in a renal Medicare-approved hospital when the decision is made, and

    b. surgery is performed no later than 2 months after the month of that decision; or

6. two months prior to the month of transplant surgery. This provision is applicable should surgery be postponed.

Eligibility and entitlement determinations under this provision are made by SSA. RR annuitants should be referred to SSA to file for Medicare under this provision. SSA will retain jurisdiction of Medicare in these cases until the beneficiary qualifies for coverage based on age or disability.

Exception: If the RRB is paying a Social Security benefit (LAF E case) and SSA determines that the beneficiary is eligible for Medicare on the basis of ESRD, the RRB will establish the Medicare record with the information provided by SSA. See FOM-810.20.

810.5.6 Federal Employment Provision

Federal employees pay the hospital insurance portion of the FICA tax on all wages paid after December 31, 1982. Federal employees earn quarters of coverage for all Federal employment after 1982 for Medicare purposes only and require the same number of quarters of coverage and regular eligibility requirements as other beneficiaries. Any Federal employees who are in an employer-employee relationship with a Federal agency at any time during January 1983 and were employed before January 1983 may receive deemed Federal quarters of coverage for their Federal service prior to January 1983, if they are required for an insured status for Medicare purposes. Federal quarters of coverage can be used alone or in combination with SS wage and/or RR compensation quarters to meet the insured status requirements for Medicare purposes. Survivors, spouses and children of individuals insured on the basis of Federal quarters of coverage are also eligible for Medicare coverage.

Eligibility and entitlement determinations under this provision are generally made by SSA. However, a disabled RR employee may use creditable Federal quarters of coverage to meet the disability freeze 20/40 test requirement for Medicare purposes at the RRB. Federal service may not be used to establish entitlement to or increase the amount of any other type of benefit.

810.10 Medicare Eligibility at RRB Based On Age

A beneficiary who meets the requirements in this section is referred to as a QRRB (qualified railroad retirement beneficiary) for Medicare purposes.

810.10.1 Employee

To be entitled to Medicare on the basis of age, an employee must:

A. Have attained age 65, and

B. Have at least 120 months of service, or if less than 120 have at least 60 months of RR service after 1995, and

C. File an application for HI or for an RR annuity as described in FOM-1-810.25.

810.10.2 Spouse

To be entitled to Medicare on the basis of age:

A. The spouse must:

1. Have attained age 65, and

2. Be eligible for a spouse's annuity or be eligible for inclusion in the O/M, and

3. File an application for HI alone or for an RR annuity, or to be included in the O/M; and

B. The employee must:

1. Be age 60-61, with 30 years of railroad service, or

2. Be at least age 62 with 120 months of service, or if less than 120 months must have 60 months of service after 1995, or

3. Have a disability freeze and be entitled to an annuity from the RRB.

NOTE: When a spouse attains age 65 before the employee meets any of the above requirements, and the spouse is not eligible for Medicare on any other earnings record, she or he should file at SSA for uninsured beneficiary Medicare (see FOM-1-810.5.4). If the spouse does not do this, she or he will be charged a penalty SMI premium rate and the SMI effective date will be determined under GEP rules, unless the spouse enrolls in a SEP, when she or he becomes eligible for Medicare based on the employee's earnings record.

810.10.3 Divorced Spouse

To be entitled to Medicare on the basis of age:

A. The divorced spouse must:

1. Have attained age 65, and

2. Be eligible for a divorced spouse's annuity, and

3. File an application for HI alone or for an RR annuity; and

B. The employee must:

1. Have attained age 62, and

2. Have at least 120 months of RR service, or if less than 120 months have at least 60 months after 1995, but not necessarily receiving an annuity.

NOTE: When a divorced spouse attains age 65 before the employee meets the above requirements, and the divorced spouse is not eligible for Medicare on any other earnings record, she or he should file at SSA for uninsured beneficiary Medicare (see FOM-1-810.5.4). If the divorced spouse does not do this, when she or he becomes eligible for Medicare based on the employee's earnings record, she or he will be charged a penalty SMI premium rate and the SMI effective date will be determined under GEP rules, unless the divorced spouse enrolls in a SEP.

810.10.4 Widow(er), Surviving Divorced Spouse and Remarried Widow(er)

To be entitled to Medicare on the basis of age, a widow(er), a surviving divorced spouse or a remarried widow(er) must:

A. Have attained age 65, and

B. Be eligible for a widow(er)'s annuity, a surviving divorced spouse's annuity or a remarried widow(er)'s annuity, and

C. File an application for Medicare alone or for an RR annuity.

NOTE: A widow(er), surviving divorced spouse, or remarried widow(er) who is paid the RLS without an election (i.e., zero annuity rate) is still considered to be a QRRB.

810.10.5 Child

To be entitled to Medicare on the basis of age, a child must:

A. Have attained age 65,

B. Be eligible for a child's annuity or be eligible for inclusion in the O/M as the child of the employee, and

C. File an application as described in FOM-1-810.25.

810.10.6 Parent

To be entitled to Medicare on the basis of age, a parent must:

A. Have attained age 65, and

B. Be eligible for a parent's insurance annuity, and

C. File an application as described in FOM-1-810.25.

810.15 Medicare Eligibility At RRB Based On Disability

A beneficiary who meets the requirements in this section is referred to as a DQRRB (disabled qualified railroad retirement beneficiary) for Medicare purposes.

810.15.1 Employee

To be entitled to disability Medicare, an employee must:

A. Be under age 65;

B. File an application and be entitled to an RR disability annuity, or file or have filed an application and be entitled to an RR age and service annuity and file an application for disability Medicare. Refer to FOM-1-810.25 for information about application requirements;

C. Meet SSA disability freeze requirements which include:

1. SSA disability medical criteria; and

2. Disability insured status requirements.

a. To have a regular DIB insured status, the employee must meet the 20/40 earnings requirement in the quarter of disability onset or in a following quarter while the employee is continuously disabled.

b. To have a health insurance only DIB insured status, the employee's disability onset date must be after the ABD and the 20/40 earnings requirement is not met on the disability onset date, but is met on the ABD; and

3. Fulfill the waiting period requirement. The waiting period is a specified period of time after the disability freeze before SSA will begin paying a disability annuity.

a. If the annuity began January 1, 1973 or later, the waiting period consists of 5 full months after the disability freeze date.

b. If the annuity began before January 1, 1973, the waiting period consists of 6 full months after the disability freeze date; and

D. Complete the qualifying period requirement. The qualifying period is a specified period of annuity entitlement following the disability freeze onset date and the waiting period when one is required.

1. Effective December 1, 1980:

a. An individual must be entitled to or deemed entitled to a disability annuity for 24 months.

b. The months of annuity entitlement do not have to be consecutive as long as any interruption in disability entitlement is less than 5 years for employees or less than 7 years for a widow or child.

Note: Effective July 1, 2001, persons who are diagnosed with Amyotrophic Lateral Sclerosis (ALS) do not have to serve the 24-month waiting period. ALS is also known as Lou Gehrig's disease. The date of entitlement to Medicare is the month following completion of the 5-month waiting period or July 1, 2001, whichever is later. The 5-month waiting period is not waived.

Example: An individual diagnosed with ALS has a disability freeze onset date is February 4, 2001. His Medicare effective date is August 1, 2001.

2. Prior to December 1, 1980:

a. An individual had to be entitled or deemed entitled to disability annuity for 24 consecutive months; or

b. An individual had to be included or could have been included in the O/M for 24 consecutive months.

810.15.2 Spouse, Divorced Spouse

A spouse or a divorced spouse may only establish entitlement to Medicare on the basis of age at the RRB. An individual who is entitled to only a spouse or divorced spouse annuity at the RRB may qualify for disability Medicare at SSA.

If the RRB is paying the spouse's Social Security disability benefits (LAF E case), RRB will establish the Medicare record with the information provided by SSA. See FOM-1-810.20.

810.15.3 Widow(er), Surviving Divorced Spouse and Remarried Widow(er)

To be entitled to disability Medicare, a widow, a surviving divorced spouse or a remarried widow must:

A. Be age at least 52, but under age 65;

B. File an application and be entitled to an RR disability annuity, or file an application and be entitled to a widow's insurance annuity, a surviving divorced spouse annuity, a remarried widow(er)'s annuity or a widow's current annuity and file an application for disability Medicare. Refer to FOM-1-810.25 for information on application requirements;

C. Meet SSA disability medical criteria, and become disabled within 7 years after the month the employee died or within 7 years after the last month of previous entitlement to monthly benefits on the employee's record; Note that while an annuity under the RRA can be granted based solely on alcohol or drug addiction without other medical impairments, that type of claim would be denied under the SS Act. Therefore, effective with applications filed January 1, 2008 or later, a disabled widow will be entitled to a disability annuity without being entitled to early Medicare if the disability decision is based solely on alcohol or drug addiction. Such cases would not be eligible for SSEB status.

D. Meet the waiting period requirements. The waiting period is a specified period of time after the applicant meets the disability requirements before SSA will begin paying a disability benefit.

   1. If the annuity began January 1, 1973 or later, the waiting period consists of 5 full months after the SS disability onset date.

   2. If the annuity began before January 1, 1973, the waiting period consists of 6 full months after the SS disability onset date.

E. Complete the qualifying period requirement. The qualifying period is a specified period of annuity entitlement following the date the applicant meets SSA disability benefit requirements and the waiting period.

   1. Effective December 1, 1980, an individual must be entitled to or deemed entitled to a disability annuity for 24 months. The months of annuity entitlement do not have to be consecutive as long as any interruption in disability entitlement is less than 7 years.

      Note: Effective July 1, 2001, persons who are diagnosed with Amyotrophic Lateral Sclerosis (ALS) do not have to serve the 24-month waiting period. ALS is also known as Lou Gehrig's disease. The date of entitlement to Medicare is the first day of the month following the 5-month waiting period or July 1, 2001, whichever is later.

   2. Prior to December 1, 1980, an individual had to be entitled or deemed entitled to disability annuity for 24 consecutive months.

Note: Months of prior entitlement to Supplemental Security Income (SSI) under the Social Security Act can be used to satisfy the 5-month waiting period for annuity entitlement and the 24-month qualifying period for Medicare for disabled widow(er)s and disabled divorced spouses. See RCM 3.2.23.

810.15.4 Child

To be entitled to disability Medicare, a child must:

A. Be at least age 20, but under age 65,

B. Must file an application (AA-19a) and meet one of the following criteria:

1. Be entitled to a RR survivor disability annuity;

2. Be eligible for inclusion in the O/M if the O/M were payable. Actual payment of the O/M rate is not necessary for the child's Medicare entitlement;

3. Qualify a spouse for an annuity. The spouse does not have to be in pay status but just eligible to receive the benefit. A disabled child may potentially allow a spouse to be eligible for an annuity. For more information, see FOM1 1310.5.3.

   Example: Leslie Bailey is a 62-year-old railroad employee who currently receives an occupational disability. However, he was denied a disability freeze for early Medicare. His wife, Erica, is 61 years old, but has not yet filed for benefits. However, she is eligible to receive an annuity because she has a minor child in her care. Their disabled daughter, Sandra, can file an application because she qualifies the spouse to receive an annuity even though she is not in pay status.

   Note: The youngest age at which a child is eligible to be included in the O/M based on disability is age 18. The youngest age at which a disabled child can qualify a spouse annuity for SSEB consideration is age 16. For these reasons, a Form AA-19a should not be developed prior to the child's attainment of age 18 in O/M cases, or age 16 in spouse cases. Actual Medicare enrollment will not occur prior to age 20.

C. Meet SSA disability medical criteria and become disabled before attaining age 22. Note that while an annuity under the RRA can be granted based solely on alcohol or drug addiction without other medical impairments, the claim would be denied under the SS Act. Therefore, effective with applications filed January 1, 2008 or later, a disabled child can be entitled to a disability annuity, or used to qualify a spouse for an annuity, without being

entitled to early Medicare if the disability decision is based solely on alcohol or drug addiction. Such cases would not be eligible for SSEB status.

D. Complete the qualifying period requirement. The qualifying period is a specified period of annuity entitlement, including cases in which there is eligibility under the O/M even if the O/M rate is not paid following the date the child meets SSA disability annuity requirements.

1. Effective December 1, 1980:

   a. The child must be entitled to or deemed entitled to a survivor disability annuity for 24 months, or

   b. The child must be included or could have been included in the O/M for 24 months.

      Note: A child does not have to complete a 5-month waiting period. However, the O/M for a disabled employee does not apply until the employee completes a waiting period. Therefore, the child 24-month qualifying period cannot begin until the employee has completed his or her waiting period. The 24-month waiting period begins the later of the employee's annuity beginning date or the date the employee attained age 62, or in the case of a disabled annuitant, five months after his or her disability freeze date.

      Note: Effective July 1, 2001, persons who are diagnosed with Amyotrophic Lateral Sclerosis (ALS) do not have to serve the 24-month waiting period. ALS is also known as Lou Gehrig's disease. The date of entitlement to Medicare is the actual or deemed disability annuity beginning date or July 1, 2001, whichever is later.

   c. The months of annuity entitlement do not have to be consecutive as long as any interruption in disability entitlement is less than 7 years.

2. Prior to December 1, 1980:

   a. The child had to be entitled or deemed entitled to a disability annuity for 24 consecutive months or,

   b. The child had to be included or could have been included in the O/M for 24 consecutive months.

810.15.5 Parent

A parent may establish entitlement to aged Medicare only.

810.20 Deemed RR Beneficiaries - Social Security Certifications

When Social Security certifies a benefit to the RRB for payment, the certification includes an entitlement determination to Part B and/or Part A of Medicare. These beneficiaries are deemed QRRBs (qualified railroad retirement beneficiaries) for Medicare purposes. If the beneficiary is currently entitled to Medicare, SSA furnishes the effective date(s) and the Part B premium rate. The RRB will then establish and maintain the beneficiary's Medicare records and will collect the Part B premium.

If the beneficiary will be entitled to Medicare in the future, the RRB will automatically enroll the beneficiary for Part A and Part B at the appropriate time. If the beneficiary does not want medical insurance coverage, (s)he may refuse the coverage by notifying the RRB when (s)he receives the notice of the entitlement effective dates.

810.25 Enrollment Requirements And Effective Date Of Coverage

To establish entitlement to Medicare coverage, an individual who is a QRRB (meets the requirements in FOM-1-810.10), a DQRRB (meets the requirements in FOM-1-810.15) or a deemed QRRB (meets the requirements in FOM-1-810.20) must file an application or be deemed to have filed an application for Medicare. The effective date of coverage is dependent on when the application is filed or deemed filed.

Enrollment for Part B is possible only during specified enrollment periods. Those periods include:

- An individual's **initial enrollment period** (IEP) is the 7-month period that begins 3 full calendar months before and ends 3 full calendar months after the month in which the individual first meets all the requirements for enrollment.

- A **general enrollment period** (GEP) occurs each year from January 1 through March 31, with coverage effective the following July 1. These periods afford enrollment opportunities to those who failed to enroll during their IEPs and to those whose enrollment was terminated.

- A **special enrollment period** (SEP) is available for individuals age 65 or over who did not enroll for Part B when first eligible or who terminated Part B enrollment because of coverage under a group health plan (GHP) based on his or her own or a spouse's current employment status. These individuals may enroll in Part B anytime while covered under the GHP or during the 8-month period immediately following the last month of GHP coverage based on current employment status.

A SEP is also available to disabled beneficiaries under age 65 who did not enroll for Part B when first eligible or who terminated Part B enrollment because of coverage under a GHP based on his or her own or spouse's current employment status or coverage under a large group health plan (LGHP) based on his or her own or a family member's current employment status. These individuals may enroll in Part B anytime while covered under the GHP/LGHP or during the 8-month period immediately following the last month of GHP/LGHP coverage based on current employment status.

In addition, Section 5115 of the Deficit Reduction Act of 2005, provides a 6-month SEP beginning January 1, 2007, for Part B and Premium Part A for an individual who:

- Is serving as a volunteer outside of the United States through a program that is sponsored by a tax-exempt organization; and

- Has (or had) health insurance that provided coverage to the individual while he/she was outside of the United States for the duration of the volunteer service.

The individual will be eligible for the SEP once he or she returns to the States.

EXCEPTION: Individuals who are entitled to Premium-HI under the Premium-HI for the Working Disabled provision are not eligible to enroll during the SEP for International Volunteers.

810.25.1 Aged Medicare - Part A

A. Application Requirements - An individual must file an application at SSA or RRB for Medicare only, or for a retirement, survivor or disability annuity.

1. Annuity Application - If an individual files an annuity application, this application is also considered an application for Medicare Part A. This application can be filed at any time. If the application is filed when the individual is age 64 and 5 months or older, enrollment will take place and the Part A effective date will be established as shown in section B. If the application is filed prior to when the individual is age 64 and 5 months, enrollment will be automatically done when the individual attains age 65 and Part A will be effective at age 65.

2. Medicare Only Application - An individual who has not yet filed for an annuity must file a Medicare only application for Part A. The application may be filed at any time as long as it is no sooner than 3 months prior to age 65. The Part A effective date will be based on when the application is filed. See Section B.

B. Effective Date - Based on when the application is filed, the effective date will be the latest of the following:

1. The first of the month in which age 65 is attained, or

   Note: An individual whose birthday is on the first day of the month is considered to have attained age 65 on the day preceding the anniversary of his/her 65th birthday. The Medicare effective date will be the first day of the month before the 65th birthday.

   Example: If the date of birth is January 1, 1927, the individual attains age 65 on December 31, 1991, and the Medicare effective date is December 1, 1991.

2. The first of the month in which the applicant attains status as a QRRB or insured status at SSA, or

3. Six months before the month an application is filed at the RRB or SSA. The effective date for the divorced spouse of a disabled employee may be 12 months before the application is filed.

   Note: Prior to September 1, 1983, applications filed at RRB could have 12 months retroactivity. Prior to March 1, 1981, applications filed at SSA could have 12 months retroactivity.

810.25.2 Disability Medicare - Part A

A. Application Requirements - An individual must file an application for a disability annuity or for an aged annuity and disability Medicare and be granted a disability freeze or meet SSA disability requirements for Medicare. Once the disability freeze or the SSA disability requirements are met, the beneficiary will be automatically enrolled for Part A after any required waiting period and qualifying period is met.

B. Effective Dates - The effective date will be the latest of the following:

1. July 1, 1973, or

2. The first day of the 25th month from the employee's RRA ABD, or the first day of the 30th month after the employee's disability freeze date.

810.25.3 Aged and Disabled Medicare - Part B Initial Enrollment Period (IEP)

A. Enrollment Period - The IEP is a 7-month period that begins with the first day of the third month before the month of age 65 attainment or the disability Medicare effective date, and ends on the last day of the third

month following the month of age 65 attainment or the disability Medicare effective date.

Deemed Initial Enrollment Period - If a person has relied on documentary evidence which indicated a date of birth later than his or her correct date of birth, a deemed IEP may be established based on that documentary evidence. A deemed IEP may also be established for a person who was born on the first day of a month and mistakenly believed that he or she attained age 65 on the anniversary of his or her date of birth when age 65 was actually attained in the preceding month.

When a deemed IEP is established for a person, all provisions of law and instructions relating to enrollment, re-enrollment, premiums and coverage will be applied as if the person's alleged date of birth, based on documentary evidence, was the actual date of birth.

B. Application Requirements - If a retirement or survivor application is filed prior to when the applicant attains age 64 and 5 months, or a disability application is filed and a disability freeze was granted, a separate application is not necessary. The individual will be automatically enrolled for Part B when enrolled for Part A. A Form G-41 will be issued. If the individual does not want Part B, the Form G-41 must be returned before the effective date on the card.

If the individual is not a resident of the United States, a Form G-44f will be sent with the Part A enrollment package which must be signed and returned if the individual wants Part B coverage.

Otherwise, an application must be filed. The application may be an annuity application or a Medicare only application. If an annuity application is filed when the individual is age 64 and 5 months and less than age 65 and 3 months, the application is considered filed in the IEP. An SMI election must be made on the application in order to receive SMI coverage. The SMI effective date will be established based on the date of filing.

A Medicare only application may not be filed sooner than 3 months before the month of age 65 attainment, or 3 months after age 65 to be considered filed in the IEP. The SMI effective date will be established based on the date of filing.

C. Effective Dates - The effective date of Part B coverage is dependent on the date an application is filed or deemed filed.

1. If the individual files an application or is deemed to have filed an application during the first 3 months of the IEP, Part B will be effective the first day of the month age 65 is attained.

2. If the individual files an application during the fourth month of the IEP (the month of attainment), Part B will be effective the first day of the following month.

3. If the individual files an application during the fifth month of the IEP, Part B will be effective the first day of the second month following the month the application is filed.

4. If the individual files during the sixth or the seventh month of the IEP, Part B will be effective the first day of the third month following the month the application is filed.

EXAMPLE:

Individual attains age 65 in January (or first month of eligibility based on disability is January) - IEP in October, November, December, January, February, March and April.							
Month of Filing or Deemed Filing →	Oct	Nov	Dec	Jan	Feb	Mar	Apr
Coverage Begins →	Jan	Jan	Jan	Feb	Apr	June	July

D. More Than One IEP – An individual under age 65 may have more than one IEP if he or she establishes entitlement to Medicare based on disability or end-stage renal disease (ESRD) more than once.

Example: The benefits and Medicare eligibility of a disabled beneficiary are terminated because the beneficiary recovers from his or her disability. If Medicare eligibility is reestablished based on a second period of disability, the beneficiary has a new IEP beginning 3 months before the new date of entitlement to Medicare.

In addition, no matter how often or under what circumstances, entitlement occurred prior to age 65, every eligible beneficiary has a new IEP at age 65.

Note: Disabled beneficiaries who either declined Part B coverage or whose Part B coverage was terminated are identified in the monthly age 65 attainment processing (FOM-1-810.30.1) and referred to the Medicare Section. The Medicare Section enrolls the individuals for Part B, and a new Medicare card (Form G-41) is released. If a beneficiary doesn't want Part B coverage, he or she can decline the coverage by completing the back of the Form G-41.

810.25.4 Aged or Disability Medicare - Part B - General Enrollment Period

An aged or disabled individual whose IEP has passed and who is not enrolled for Part B, or has refused or terminated Part B coverage, may enroll or re-enroll for Part B coverage only in a General Enrollment Period (GEP) (unless a Special Enrollment Period (SEP) is applicable). Since April 1, 1981, there is no limit to the number of times an individual may enroll for Part B coverage. Any individual previously prevented from re-enrolling for Part B because he or she voluntarily terminated coverage may enroll for coverage during a GEP.

Enrollments in a GEP are subject to penalty premium rates. The monthly premium is increased for each 12-month period that an individual could have enrolled for Part B, but did not. However, for any month that the individual is covered under a group health plan (GHP) or large group health plan (LGHP), that month is excluded from the penalty calculation if proof of GHP/LGHP coverage is submitted.

In addition, if a beneficiary enrolled in Part B prior to age 65 during a GEP, any premium surcharges the beneficiary is paying will be rolled back once he or she reaches age 65. The beneficiary will pay the basic rate beginning with the month age 65 is attained. This provision assures that all individuals attaining age 65 are treated the same with respect to Part B premium computation.

A. GEP - Current Requirements

1. Enrollment Period - The GEP is a 3-month period that begins on January 1 and ends on March 31 of each year.

2. Application Requirements - An individual who previously filed for Part A and refused Part B, or elected Part B and terminated Part B, may complete a Form G-44, Form G-44b or submit a signed statement electing Part B.

   An individual who is filing an annuity application or a Medicare only application in January, February or March and his or her IEP has elapsed, must elect Part B coverage on the application.

   An individual who is filing an annuity application or a Medicare only application to establish Part A, in April through December and his or her IEP has elapsed, is deemed to have filed for Part B in the next GEP. This is commonly known as a deemed GEP. The Medicare Section should be notified via e-mail when the field office recognizes that the application is for a deemed GEP. The Medicare Section will establish a call-up for the applicant. At the appropriate time, the individual will be enrolled for Part B.

3. Effective Date - The effective date will be July 1 of the year in which the application is filed. If a deemed GEP, the effective date will be July 1 of the following year.

B. GEP - Requirements Prior to October 1, 1981

1. 4-1-81 through 9-30-81 - During this period, individuals whose IEP had ended could apply for Part B coverage at any time. The effective date of Part B coverage was the first day of the third calendar month following the month in which the application was filed.

2. Before 4-1-81 - The first GEP began 10-1-67 and ended 4-1-68. Subsequent GEPs began on January 1 and ended on March 31 of each year. SMI coverage for a person who enrolled in a GEP began on July 1 of the year in which the person enrolled. All individuals were considered eligible to enroll for Part B during the GEP, provided their Part B coverage was not terminated twice. There were two exceptions:

- The terminations were followed by a period of State-Buy In coverage.
- The terminations occurred during entitlement to disability Medicare and the beneficiary became entitled to aged Medicare.

810.25.5 Special Enrollment Period (SEP)

A Special Enrollment Period (SEP) is provided for individuals age 65 or over who did not enroll for Part B when first eligible or who terminated Part B enrollment because of coverage under a group health plan (GHP) based on his or her own or a spouse's current employment status. These individuals may enroll in Part B anytime while covered under the GHP or during the 8-month period immediately following the last month of GHP coverage based on current employment status.

A SEP is also available to disabled beneficiaries under age 65 who did not enroll for Part B when first eligible or who terminated Part B enrollment because of coverage under a GHP based on his or her own or spouse's current employment status, or coverage under a large group health plan (LGHP) based on his or her own or a family member's current employment status. These individuals may enroll in Part B anytime while covered under the GHP/LGHP or during the 8-month period immediately following the last month of GHP/LGHP coverage based on current employment status.

A 6-month SEP is also available for individuals who performed volunteer service outside the U.S. through a program sponsored by a tax-exempt organization and

who have health insurance that provided coverage to the individual while he/she was outside the U.S. for the duration of the volunteer service. Under the SEP provision, qualifying volunteers can delay enrollment in Part B or terminate such coverage for the period of service outside the U.S. and re-enroll without incurring a premium surcharge. **EXCEPTION:** Individuals who are entitled to Premium-HI under the Premium-HI for the Working Disabled provision are not eligible to enroll during the SEP for International Volunteers.

Note: A disabled beneficiary can qualify for a SEP on the basis of GHP coverage based on his or her own **or spouse's** current employment status, **or** LGHP coverage based on his or her own **or a family member's** current employment status. A domestic (or life) partner who is under age 65, entitled to Medicare based on a disability and has coverage under an LGHP based on the partner's enrollment in the plan is considered to be a family member for the purposes of a SEP.

Note: When an individual is notified that his or her GHP or LGHP coverage is being terminated retroactively, he or she may enroll in Part B during the 8-month period that begins the first month following the month of notification.

SEPs were first provided for aged beneficiaries beginning November 1984, and for disabled beneficiaries beginning January 1987. Individuals with end-stage renal disease (ESRD) are not eligible for a SEP.

A. Requirements

To be eligible for a SEP, an individual must meet the following requirements:

1. No previous Part B enrollment. An individual who did not enroll in the Initial Enrollment Period (IEP) had to be covered under a GHP based on his or her own or a spouse's current employment status when first eligible for Part B, i.e., the month of age 65 attainment or the 25th month of disability entitlement. When coverage was under an LGHP, the coverage had to be based on the individual's own or a family member's current employment status.

2. Previous Part B entitlement. If the individual enrolled in Part B during an IEP or General Enrollment Period (GEP), but the Part B coverage terminated, the GHP coverage had to be based on the individual's own or the spouse's current employment status at the time of the Part B termination and for all the months thereafter. When the individual was covered under an LGHP, the coverage had to be based on the individual's own or a family member's current employment status

   Note: If the individual previously enrolled during the GEP, the individual must have been enrolled in Part B or covered under a GHP/LGHP in

the first month of eligibility for Part B, i.e., the month of age 65 attainment or the 25th month of disability entitlement

3. Subsequent SEP. If the individual enrolled in Part B during an SEP, and the Part B coverage was later terminated, the individual had to be covered under a GHP based on his or her own or a spouse's current employment status at the time of the Part B termination. If the individual was covered under a LGHP, the coverage had to based on the individual's own or a family member's current employment status at the time of the Part B termination.

   Note: The SEP provisions allow an 8-month period after the month GHP or LGHP coverage based on current employment status ends to enroll in Part B. When employment or GHP/LGHP coverage ends, but before the 8-month period expires the beneficiary is once again covered under a GHP or LGHP based on current employment status, the SEP is deemed not to have occurred. For example, Employee A was covered under a GHP for many years based on her own employment. She retired in November 2004. However, in March 2005, she begins working again and is once again covered under a GHP. Employee A retains full SEP enrollment rights because less than 8 months elapsed between her retirement and subsequent coverage under a GHP.

   Note: There is no limit to the number of subsequent SEPs. However, to have a subsequent SEP, the individual must have enrolled during the earlier SEPs available to him or her. Enrollment during the GEP that falls within an SEP (with a choice of the July 1 date of entitlement based on the GEP) satisfies the requirement for an earlier SEP.

4. SEP for International Volunteers. The SEP provision for international volunteers allows an individual to enroll during an SEP if he or she qualifies as a volunteer working outside the U.S. for a tax-exempt sponsoring organization, has or had health insurance coverage while outside of the U.S. for the duration of the volunteer service and meets one of the following requirements:

   - If he or she did not enroll in the IEP, the beneficiary had to meet the requirements above in the first month of eligibility for Part B and all months thereafter.

   - If he or she enrolled during the IEP and later terminated coverage, the beneficiary had to meet the requirements in the first paragraph above in the month of the Part B termination and all months thereafter. If he or she previously enrolled during the GEP, he or she must have enrolled in Part B or meet the requirements in the first paragraph above in the first month of eligibility.

See RCM 3.2.131 for additional information.

B. Effective Date

An individual can enroll under the SEP provisions while still working. If an individual enrolls in Part B while still covered under a GHP/LGHP or during the first full month when not enrolled in a GHP/LGHP based on current employment status, the individual has the option of choosing an effective date of:

- the first day of the month of his or her Part B enrollment, or
- the first day of any of the following 3 months.

If the individual enrolls in Part B during any of the remaining 7 months of the SEP, coverage begins with the first day of the month after the month of enrollment.

Examples of How Part B Effective Date is Determined

If an individual's last day of coverage under a GHP/LGHP based on current employment status is March 13, 2005, the following applies:

1. If the individual files for Part B in February 2005, he or she can elect coverage beginning February 1, March 1, April 1, or May 1.
2. If the individual files for Part B in March 2005, he or she can elect coverage beginning March 1, April 1, May 1 or June 1.
3. If the individual files for Part B in April 2005, he or she can elect coverage beginning April 1, May 1, June 1 or July 1.
4. If the beneficiary files for Part B at any time during the period of May 1 through November 30, 2005, i.e. the remaining 7 months of the SEP, the Part B coverage is effective the first day of the month after the month of enrollment.

   SEP for International Volunteers. SEP eligibility for international volunteers became effective January 1, 2007. An individual who qualifies as an international volunteer effective July 1, 2006 or later is eligible to enroll in Part B during the SEP. If the last month of volunteer service was July 2006, then January 2007 was the last month of the SEP. If the last month of volunteer service was August 2006, then February 2007 was the last month of the SEP, etc.

   The SEP for international volunteers is the 6-month period that begins the earlier of the first day of the month following the month for which the:

- Individual was no longer serving as a volunteer outside the U.S.
- Sponsoring organization no longer has tax-exempt status; or
- Individual no longer has health insurance that provides coverage outside the U.S.

NOTE: Enrollment in Medicare Part B may not occur prior to the end of the IEP. For international volunteers, coverage is effective the first day of the month following the month of Part B enrollment.

C. Definitions

The terms described in this section are those used with the SEP. Use the descriptions of these terms to decide:

- If an individual is eligible for a SEP, and
- When the SEP should begin.

Note: The terms may also be used in determining whether a premium surcharge rollback applies and for what months.

Term	Definition
Group Health Plan (GHP)	A GHP is any plan of, or contributed to, by one or more employers to provide health benefits or medical care (directly or otherwise) to current or former employees, the employer, or their families. The term GHP also applies to self-insured plans, plans of governmental entities (Federal, State and local), and employee organizational plans (e.g., union plans or employee health and welfare funds). It also includes employee pay-all plans (i.e., plans under the auspices of an employer or employee organization, but which receive no financial contribution from them.) **Note**: A **self-insured plan** is a health insurance plan that an employer establishes to pay the health care expenses of its employees. Unlike a group health plan that requires the employer to pay premiums to a health insurer, a self-insured plan requires the employer to pay the health care expenses of employees as the expenses are incurred. The employees may or may not be required to contribute to the self-insured plan. **Note**: The term GHP does not include plans that are unavailable to employees, i.e., a plan that only covers **self-employed** individuals. For example, a self-employed individual may be covered under a

	health plan offered by a professional association, lodge, fraternal organization, etc. If the health plan is available to one or more employees of the association, lodge or organization, or one or more employees of the self-employed member of the association, lodge, or organization, then the health plan can be considered a GHP (or LGHP if there are 100 or more such employees). If the health plan is only available to self-employed members and not available to any employees, then the plan is not a GHP or LGHP. The employer does not have to be in the United States, and the employee is not required to be working in the United States. A person working for a foreign employer, who has a plan that meets the definition above, is considered covered under a GHP for purposes of the SEP and/or premium surcharge rollback. For SEP purposes, the GHP can be of **any** size. However, when referring to a GHP for the disabled, the term refers to a plan of any size below 100 employees. **NOTE:** When used in these instructions, the term GHP refers specifically to a **group health plan based on the current employment status of the beneficiary or the beneficiary's spouse.** **NOTE:** COBRA coverage is not a GHP based on current employment status. COBRA coverage does not qualify an individual for a SEP.
Current Employment Status	In general, an individual has "current employment status" if he/she is **actively working** as an employee, is the employer (including a self-employed individual), or is associated with the employer in a business relationship. An individual also has "current employment status" if he or she is **not actively working, but meets all of the following conditions:** retains employment rights in the industry; employment has not been terminated by the employer (if the employer provides the coverage); or membership in the employee organization has not been terminated (if the employee organization provides the coverage); is not receiving disability benefits from an employer for more than 6 months;

	is not receiving railroad retirement or Social Security disability benefits; and has employment based GHP coverage that is **not** COBRA continuation coverage. Persons who retain **employment rights** include but are not limited to: those who are on strike, furloughed, temporarily laid off or who are on sick leave; teachers and seasonal workers who normally do not work throughout the year; and individuals who have health coverage that extends beyond or between periods of active employment. The following information further defines “current employment status” for specific situations. **1. Individual Covered Under A Retirement GHP is Rehired** A group health plan based on former employment becomes a GHP based on “current employment status” **if** the employer who is furnishing the retirement GHP rehires the individual **and** the amount of work the individual performs is sufficient to earn coverage from the employer had the individual not retired. The employment under the GHP is attributed to current employment status. This is true even if the payment for the GHP coverage is deducted from a pension or annuity payment. If employed by an employer other than the one providing the group health plan coverage however, the GHP is a retirement plan and is **not** based on current employment status. **2. Employment Status of Senior Judges** Senior Federal judges are retired judges of the U.S. court system and the Tax Court. They may continue to adjudicate cases, but they are entitled to full salary as a retirement benefit whether or not they perform judicial services for the Government. The remuneration they receive as senior judges is not regarded as wages for Social Security retirement test purposes. Since they are considered retired for Social Security purposes, they are not considered to have current employment status for purposes of the SEP and premium surcharge rollback.

	3. Clergy and Members of Religious Order Members of religious orders who have not taken a vow of poverty are considered to have current employment status with the order if: the religious order pays FICA taxes on behalf of that member; or the individual receives remuneration from the order for services furnished, regardless of whether the order pays FICA taxes on behalf of that member. Members of religious orders who have taken a vow of poverty are not considered to have current employment status if the services performed as a member of the order are considered employment for social security purposes only because the Order elected social security coverage under 3121(r) of the Internal Revenue Code. **4. Individuals Serving as Volunteers** Volunteers are considered to have current employment status if they perform services or are available to perform services for an employer and receive payment for their services. For example, AmeriCorps (which includes VISTA, the National Civilian Community Corps and State and National volunteers) and Peace Corp volunteers are considered to have current employment status since they receive remuneration from the Federal Government. Payment may be monetary or non-monetary. Benefits (including health benefits) that a volunteer receives are considered as payment if the benefits are subject to FICA taxes under the Internal Revenue Code.
Large Group Health Plan (LGHP)	**The term "LGHP" refers exclusively to the disabled.** An LGHP is a group health plan that is available to employees of one or more employers who normally employed at least 100 employees on at least 50 percent of its business days during the previous calendar year. If a plan is a multi-employer plan, such as a union plan, which covers employees of some small employers and employees of at least one employer that meets the 100 or more employees' requirement, Medicare is secondary payer for all employees enrolled in the plan. In this situation, **all** the employers (large and small) in the multi-employer plan are considered "large," and their plan coverage is considered LGHP coverage.

	NOTE: When used in these instructions, LGHP means specifically a **large group health plan covering a disabled beneficiary.**
LGHP Is No Longer a Large Plan	An LGHP is no longer considered a large plan effective January 1 of the year **following the year** in which the employer no longer employed 100 employees on at least 50 percent of its business days in that year. For purposes of these instructions, it is to be treated as a GHP at that point. The CMS Regional Office should resolve any questions about the size of a plan.
Medicare Secondary Payer (MSP) Provisions	In general, Medicare is secondary payer for services covered under any of the following: Group health plans (GHPs) of employers that employ at least 20 employees and that cover Medicare beneficiaries age 65 or older who are covered under the plan by virtue of the individual's current employment status with an employer or the current employment status of a spouse of any age. Large group health plans of employers that employ 100 or more employees and that cover Medicare beneficiaries who are under age 65, entitled to Medicare on the basis of disability, and covered under the plan by virtue of the individual's or a family member's current employment status with an employer. Medicare is secondary for these individuals even if the employer policy or plan contains a provision stating that its benefits are secondary to Medicare benefits or otherwise excludes or limits its payments to Medicare beneficiaries.
Spouse	An individual is considered a spouse for SEP purposes if he/she is a: Spouse for RRA benefits or Social Security Title II purposes Divorced Spouse – if a divorced spouse is covered under the GHP or LGHP of a former spouse, the divorced spouse is considered to be a “spouse” for purposes of these provisions even though he/she may not otherwise meet this definition. Due to the repeal of the Defense of Marriage Act (DOMA) on June 26, 2013, we are now able to process SEP requests for individuals with

	GHP or LGHP coverage based on the current employment of a same-sex spouse. Same-sex marriages are treated the same as opposite-sex marriages for purposes of the SEP. When considering a spouse for SEP purposes, the following individuals cannot be recognized as a spouse under any circumstances: Domestic (or life) partner age 65 or older and covered under a GHP, and Domestic (or life) partner under age 65, entitled to Medicare based on disability, and covered under a GHP. This provision does not apply to domestic (or life) partners under age 65 who are entitled to Medicare based on disability and have LGHP coverage as a "family member." Under the SEP provisions, a domestic partner who has coverage under an LGHP based on the other partner's enrollment in the plan, is considered a family member. Prior to December 2004, CMS' policy was that the SEP provision applied to a domestic partner if the GHP included the domestic partner within the definition of "spouse," i.e. where domestic partners were given "spousal" coverage by the plan. An individual who refused SMI in the belief that he or she was eligible to enroll during a SEP as a domestic partner, and whose IEP began December 2004 or earlier, may be able to enroll under equitable relief provisions.
Family Member	Family member is defined as "a person who is enrolled in an LGHP based on another person's enrollment." The term encompasses not only individuals who are related (by blood, marriage or adoption), but also individuals who are related provided they are enrolled in the LGHP based on the worker's enrollment. Family members include, but are not limited to a spouse, a natural, adopted, foster or step-child, a parent, or a sibling. Domestic (or life) partner - a domestic partner who is under age 65 and who has coverage under an LGHP based on the other partner's enrollment in the plan, is considered a family member for the purposes of these provisions.

Sponsoring Organization	A sponsoring organization may be a social, religious, educational, scientific, and/or charitable organization as described in section 501(a) and (c)(3) of the Internal Revenue Code of 1986. The sponsoring organization can be a corporation, or any community chest, fund or foundation organized and operated exclusively for religious, charitable, scientific, testing for public safety, literary, educational purposes, or to foster national or international amateur sports competition. Also included are organizations for the prevention of cruelty to children or animals.

D. Application Requirements

Field office personnel must determine if the requirements for a SEP exist before they secure the necessary application for enrollment and evidence of coverage under a Group Health Plan (GHP) or Large Group Health Plan (LGHP). Field office personnel must determine the following:

- If the health plan is a GHP or LGHP, and
- Whether the individual's GHP coverage was based on his or her own or the spouse's current employment; or if disabled, whether the individual's LGHP was based on his or her own or a family member's current employment status.

  Use the following chart to determine whether the individual needs GHP or LGHP coverage to qualify for a SEP:

Type of Beneficiary	Beneficiary Can Qualify for SEP On Basis Of:	If Coverage is Based on Current Employment Status of:
Aged	GHP	Self or spouse
Disabled	GHP	Self or spouse
	LGHP	Self or family member

Note: Careful questioning is needed to determine whether the GHP or LGHP is based on a current employment status. It is not sufficient to ask "Are you covered by an employer group health plan? You must also determine if the coverage is based on a current work status. Remember that GHP or LGHP coverage based on a retirement plan does not qualify an individual for a SEP. (See FOM-1-810.35.2.1) if an individual does not qualify for a

SEP on the basis of GHP or LGHP based on a current employment status.)

1. Application

- If the individual is filing an application for benefits at the same time he or she is enrolling for Part B during a SEP, a separate application is not required. Instead, answer the appropriate Medicare-related questions on APPLE.

- If the individual is not filing for benefits at the same time he or she is enrolling for Part B, obtain a completed Form G-44b. See FOM-I-1720 for completion instructions.

- Here are the Medicare-related questions on APPLE that may need to be completed when enrolling an individual during a SEP:

  Note: For purposes of items on APPLE, consider that "EGHP" refers either to a GHP or LGHP.

Beginning Dates, Filing Dates, Medicare

- Applicant is 64 years and 5 months of age or older? Y/N

Medicare Part B Enrollment

- Currently entitled to Part B? Y/N
- Recently filed for Part B? Y/N
- I wish to enroll for Part B Medicare? Y/N

Medicare Part B Special Enrollment

- Current EGHP Coverage? Y/N
- Date Last Worked
- EGHP Beginning Date
- EGHP Ending Date
- Previous EGHP Coverage? Y/N
- Special Enrollment Period? Y/N
- Part B Effective Date

Note: If the applicant has GHP coverage, but it is not based on his or her own or the spouse's current employment status (or if disabled, the applicant does not have LGHP coverage based on his or her own or a family member's current employment status), answer the first question "No."

Proof of Employer Group Health Plan Coverage

- Name of Employer
- Name of EGHP
- Date Employment Ended or Will End
- EGHP Beginning Date
- EGHP Ending Date
- Document Type

Notes:

The items on the Proof of Employer Group Health Plan Coverage screen are to be answered with respect to the individual with the "current employment status" on whose GHP or LGHP coverage the beneficiary qualifies for a SEP.

If the name of the GHP or LGHP is not known, enter "Unknown" for name of EGHP.

2. Proof of GHP or LGHP

The preferred proof of GHP or LGHP coverage based on a current employment status is a completed Form RL-311-F. Other acceptable proofs are a letter on stationary from the employer or insurance company (GHP or LGHP) showing the information requested on Form RL-311-F, or Form CMS-L564.

Enter the proof on APPLE by completing the items on the Proof of Employer Group Health Coverage screen. See item 1 above.

SEP for International Volunteers. Under the SEP provision, qualifying volunteers can delay enrollment in Part B or terminate such coverage for the period of service outside the U.S. and re-enroll later after they return to the U.S. without incurring a premium surcharge for late or re-enrollment. If an individual requests termination of Part B because he or she will be serving as a volunteer outside of the U.S., field office personnel will advise the

beneficiary of the eligibility requirements that must be met in order to re-enroll during the SEP for International Volunteers. The Medicare Section (MS) will handle the Part B termination.

When the beneficiary is ready to enroll or re-enroll, field office personnel is responsible for collecting the required proof and documentation of the volunteer service, tax-exempt status of the sponsoring organization, and health insurance coverage. Field office personnel will image the application and documentation and forward them to the MS enrollment inbox. **The evidence may be in any form, as long as there is no question that the evidence is from the sponsoring organization, health insurance plan, and all required information is present.** If the evidence of volunteer service, tax-exempt status of the sponsoring organization, and health insurance coverage outside of the U.S. is obtained by telephone, field office personnel must record the information on the Contact Log.

- Evidence of Volunteer Service and Tax-Exempt Status of the Sponsoring Organization – The evidence must show that the individual served as a volunteer outside of the U.S. through a program sponsored by a tax-exempt organization.

- Evidence of Health Insurance Coverage Outside of the U.S. – The evidence must show that the individual had health insurance that provided coverage for the individual outside of the U.S. for the duration of the volunteer service.

All Medicare Part B enrollment requests will be processed by the field office. The field office will then image the SEP enrollment package containing the Part B enrollment request, evidence of volunteer service, tax-exempt status of the sponsoring organization, and health insurance coverage outside of the U.S. to the Medicare Section. Field office personnel may give the individual Form G-93 (found on RRAILS) that requests the information below. It is up to the individual to obtain the information from the necessary parties:

1. For evidence of volunteer service and the tax-exempt status of the sponsoring organization, request the following information:

a. Name, address, and telephone number of the sponsoring organization

b. Is your organization tax exempt as defined in section 501(a) of the Internal Revenue Code of 1986? [ ] YES [ ] NO

c. Does your organization meet the definition in section 501(c)(3) of the Internal Revenue Code of 1986? [ ] YES [ ] NO

d. If yes to either of the above questions, provide your tax identification number.

e. Did the individual serve as a volunteer outside of the United States as a member of your organization? [ ] YES [ ] NO

f. Date volunteer service outside of the United States began:

_____

g. Date volunteer service outside of the United States ended:

_____

2. For evidence of health insurance coverage outside of the United States, request the following information:

a. Name, address, and telephone number of health insurer

b. Does (or did) the individual have any health insurance that provides (or provided) coverage for services outside of the United States? [ ] YES [ ] NO

c. When did the health insurance begin?

_____

d. When did the health insurance end?

_____

If the individual is enrolling in Part B during the GEP, the field office will forward the enrollment request to MS for handling. Field office personnel should notate “Premium Surcharge Relief – INT’L VOLUNTEERS” on the request. All necessary information should be included.

If the individual is already enrolled in Part B and is requesting premium surcharge relief, field office personnel should notate “Premium Surcharge Relief – INT’L VOLUNTEERS” on the request. All necessary evidence should be included and forwarded to MS to re-calculate the penalty rate.

810.25.6 Unique Enrollment Situations - Parts A and B

A. Overlapping Initial and General Enrollment Periods - If an application is filed and an individual's IEP and GEP overlaps the individual will be enrolled for Parts A and B based on the IEP. If an application is filed after

the end of the IEP but before the end of the GEP, the Part B effective date will be July 1 of the year in which the person enrolled.

B. Overlapping IEP/SEP - An individual cannot claim a SEP which is within his/her IEP. An application that is filed after the individual's GHP or LGHP coverage has terminated, but before the end of the IEP must be enrolled for Part B based on the IEP. Regulations do not permit an individual to claim an SEP during an IEP.

C. Overlapping IEP/SEP/GEP - If an application is filed and an individual's IEP, GEP and SEP overlap, the individual will be enrolled for Part B based on the IEP. If an application is filed after the end of the IEP and a GEP and SEP overlap, the individual may choose either a GEP or SEP.

D. Overlapping Disability and Age 65 Enrollment Periods - In some instances, a beneficiary's Part B IEP period for disability Medicare will overlap the Part B IEP period for aged Medicare. In such instances the beneficiary will be enrolled for Parts A and B based on the earliest IEP.

E. Waiver of Part B Enrollment Period Requirements - Relief is available to certain individuals whose SMI enrollment rights were prejudiced due to action, inaction or error of government officers, employees or agents. The RRB is authorized to establish an enrollment and coverage periods and to adjust premium liability if there is evidence or record showing that the individual took reasonable, appropriate and timely measure to assert his rights, and due to administrative fault or other action these rights are likely to be seriously impaired unless relief is given. See section 810.35.

810.25.7 Aged Medicare - Parts A and B - Uninsured Individuals

Those individuals not insured at either the RRB or SSA may enroll for Aged Medicare Part B only or Aged Medicare Parts A and B at SSA. The IEP and GEP enrollment provisions for Part B insured beneficiaries apply to both Parts A and B for uninsured beneficiaries.

810.30 Application Requirements

810.30.1 Beneficiary on the Rolls During IEP

Annuitants and beneficiaries of SS benefits certified by the RRB currently on the rolls (whether payment is in force or in suspense) is not required to submit an application or additional evidence for HI or SMI. The annuity application or supplement previously filed automatically establishes timely Medicare entitlement. The automatic enrollment process begins 6 months prior to attainment of age 65. Individuals who are automatically enrolled through this process are referred to as attainments. A Medicare record is established and a Form G-41 is released before the beginning of the IEP. However, if an individual

is receiving an annuity based on age and wishes to establish earlier Medicare eligibility based on disability, additional information will be required as described later in this section.

IPIs are enrolled through manual call-up and processing in the Medicare Section. No field office action is generally required to enroll an IPI for Medicare.

If an individual is automatically enrolled for Medicare (Part A and B), he or she may refuse the coverage any time before entitlement begins without penalty.

810.30.2 Beneficiary Files for An Annuity During or After IEP

Providing this is the first application filed and the beneficiary has not previously refused Medicare Part B coverage, a separate application is not required to establish HI or SMI entitlement. However, the applicant in these instances must answer the question on the annuity application referring to whether he or she wants SMI coverage. The HI coverage effective date may be established retroactive for up to 6 months from the filing date (12 months for the divorced spouse of a disabled employee). However, the SMI coverage effective date will be determined as though the beneficiary enrolled in a GEP unless the application is filed during the IEP. Therefore, if the annuity application is filed between January l and March 31, and SMI is elected, SMI coverage begins July 1. Otherwise, the application is used to deem the individual's enrollment in the next GEP unless a "no" election was made on the annuity application. If a "no" election is made, the beneficiary must file Form G-44b or send a signed statement to elect SMI during a GEP or SEP.

If the beneficiary does not answer the question on the annuity application about SMI coverage and is not enrolled in Medicare under another record, SMI coverage would have to be elected during a SEP or GEP. Enrollment in this situation could not be automatic.

810.30.3 Employee Filing For or Entitled to an Annuity Based on Age Wants to Establish Early Medicare Based on Disability

In addition to the annuity application and evidence that is being or has been developed previously, a supplemental Form AA-ld must be developed to establish entitlement to disability Medicare (HI and SMI). The Form AA-ld should be marked "Application for Disability Freeze." In addition, proof of disability, Form G-251 should be developed.

810.30.4 Widow(er), Surviving Divorced Spouse or Remarried Widow(er) Filing for or Entitled to an Annuity Based on Age Wants to Establish Early Medicare Based on Disability

In addition to the annuity application and evidence required for payment of the annuity, a Form AA-17b must be developed to establish entitlement to disability

Medicare (HI and SMI). In addition, proof of disability should be developed. Also develop Form G-251 for a widow(er), but not for a surviving divorced spouse or a remarried widow(er).

810.30.5 Employee Filing for Medicare Only

An employee who does not wish to retire but wants to establish entitlement to Medicare only, must file a Form AA-6 and proof of age. The application will establish entitlement to HI and entitlement to SMI if the employee elects coverage and the application is filed during his or her IEP, GEP, or a SEP.

An employee who previously filed an informational application while age 62 to 64 to qualify his or her spouse for Medicare must complete a new Form AA-6 during an open enrollment period to qualify for Part A coverage and to enroll for Part B coverage.

In addition, the following evidence may be required as indicated:

Evidence	When required
Proof of Military Service	If needed to establish 120 months of RR service; or 60 months of RR service after 1995.
Lag Service statement from employer	If needed to establish 120 months of RR service; or 60 months of RR service after 1995.

In a letter to the RR contact official, request a report of the number of months of lag service through the application filing date. Submit a copy of the letter with the application. The reply should be sent to MS.

810.30.6 Spouse or Divorced Spouse Filing for Medicare Only

A spouse who meets the requirements in section 810.10.2 or a divorced spouse who meets the requirements in section 810.10.3 and wants to establish entitlement to Medicare must file a Form AA-7.

The application will establish entitlement to HI, and entitlement to SMI if the spouse or divorced spouse elects coverage and the application is filed during the IEP, a GEP, or a SEP. In addition, the following evidence is required:

Evidence	When required
Proof of age of spouse or divorced spouse	Always.

Proof of age of employee	Always. (Will already be in file if employee is receiving annuity.)
Proof of marriage to employee	Always.
Proof of divorce from employee	Always from divorced spouse.
Proof of termination of prior marriage	Only if there is reason to doubt that the marriage terminated.
Proof of termination of latest marriage	Always from a divorced spouse who remarried.
Form G-346 completed by employee	Required only when legal spouse is filing and the spouse's application filing date is less than 90 days from the voucher date of the employee's initial award. When the employee and spouse are separated, request the Form G-346 directly from the employee. If the employee refuses to complete Form G-346, the spouse must submit statements concerning the employee's prior marriages from two other persons who know the facts, preferably relatives of the employee. If she cannot do that, she should submit a statement explaining why. The file will be reviewed to determine if additional evidence (e.g., a search of court records) is required. NOTE: When completing Form G-346 that accompanies a spouse Medicare-only application, item 8 of Form G-346 does not need to be completed.
Proof of employee's military service	If needed to establish 120 months of RR service; or 60 months of RR service after 1995.
Employee's lag service (statement from Employer)	If needed to establish 120 months of service; or 60 months of RR service after 1995. In a letter to the RR contact official, request a report of the number of months of lag service through the application filing date. Submit a copy of the letter with the application. The reply should be sent to MS.

810.30.7 Widow(er), Surviving Divorced Spouse or Remarried Widow(er) Filing for Medicare Only

A widow(er), surviving divorced spouse or remarried widow(er) who meets the requirements in section 810.10.4 and wishes to establish entitlement to Medicare must file a Form AA-8.

The application will establish entitlement to HI and entitlement to SMI if the applicant elects coverage and the application is filed during the IEP, a GEP, or a SEP. In addition the following evidence is required:

Evidence	When required
Proof of death of employee	Always.
Proof of age	Always.
Proof of marriage to employee	Always.
Proof of termination of prior marriage	If there is doubt a prior marriage ended.
Proof of divorce	Always from a surviving divorced from employee spouse.
Proof of remarriage(s)	Always from remarried widow or a surviving divorced spouse who remarried.
Proof of military service	If needed to establish 120 months of RR service; or 60 months of RR service after 1995.
Employee's lag (statement from employer)	If needed to establish 120 months of RR service; or 60 months of RR service after 1995. In a letter to the RR contact official, request a report of the number of months of lag service through the month of death. Submit a copy of the letter with the application. The reply should be sent to MS.

810.30.8 Child Filing for Medicare Only

A child who is eligible as described in section 810.15.4 and who meets the relationship, dependency and O/M requirements, but who is not receiving an annuity or considered in the payment of the employee or spouse annuity, must file a Form AA-19a to establish entitlement to Medicare. Since the youngest age at which a child is eligible to be included in the O/M based on disability is age 18, and age 16 is the youngest age at which a disabled child can qualify a spouse

annuity for SSEB consideration, a Form AA-19a should not be developed prior to the child's attainment of age 18 in O/M cases, or age 16 in spouse cases. (To be entitled to Medicare, the child must have been eligible for O/M inclusion for at least 24 months and be at least 20 years of age.)

The application will automatically enroll the child for HI and SMI when all entitlement requirements are met. If the child does not want SMI coverage, refusal of coverage can be made by notifying the RRB upon receipt of the notice informing of the entitlement effective date. In addition, the following evidence is required: proof of relationship, proof of the child's age and medical evidence.

810.30.9 All Beneficiaries, Electing Part B After Part A Established

A. Separate application not required - A separate application to establish Part B coverage is not required, if a beneficiary:

1. Filed an annuity application or a Medicare only application during the previous year, and

2. Part A had not been established prior to that application at either SSA or RRB, and

3. The beneficiary elected Part B coverage on the application.

Beneficiaries meeting the above requirements are deemed to have filed during a GEP.

B. Separate application required - Beneficiaries who do not meet the requirements in A. above may apply for Part B coverage by submitting one of the following during a General Enrollment Period (January l through March 31 of each year):

1. Form G-44 - This form is released by headquarters to beneficiaries in the United States when Part B coverage was refused, withdrawn or terminated in the previous year, or

2. Form G-44b (see FOM-I-1720), or

3. A statement which clearly states the individual wants to enroll for Part B coverage.

The beneficiary will be enrolled for medical insurance effective July of the year in which the Forms G-44, G-44b or a statement is submitted.

810.30.10 All Beneficiaries Filing In A SEP

See FOM-I-810.25.5 for information about the application requirements for individuals filing for Part B during a SEP.

810.35 Equitable Relief

810.35.1 General

The 1972 amendments to the Social Security Act authorized relief when an individual's SMI enrollment, termination or coverage rights are prejudiced because of an error, misrepresentation or inaction of an employee or agent of the Government. In such situations, RRB may take whatever action is necessary to prevent or correct inequity to the individual, including (but not limited to) the designation of an enrollment and coverage periods, and appropriate adjustment of premium liability. The effective date of this amendment was 7-1-66. The equitable relief provisions may be applied to any eligible Part B enrollee.

To be eligible for equitable relief, evidence of the following elements must exist:

- The individual took such appropriate and timely measures to assert his or her rights as could reasonably be expected under the circumstances, and

- Because of administrative fault, delay or erroneous action or inaction by an employee or agent of the RRB or another Federal government agency, the individual's enrollment or premium rights would be impaired unless relief is given. (An "agent" of the Federal government is one who is authorized to act on behalf of the Federal government in matters pertaining to Medicare, such as an employee of the Part B carrier.)

Relief cannot be provided merely because of hardship or because of "good cause" for failure to enroll. There must be some erroneous action or inaction by the Federal government which is prejudicial to the rights of the individual. Whether or not the individual used Medicare coverage is not a factor in determining if equitable relief may be granted.

The elements which must be present in every case where equitable relief is granted are:

A. Government error, misrepresentation, or inaction; and

B. Prejudice to the individual's SMI rights. This may consist of carrying private insurance that the individual did not need, electing surgery in advance of entitlement because he or she was misinformed about their entitlement date, missing an enrollment period, being unable to pay a large premium arrearage which accrued due to government delay, or any other hardship with health care needs that can be traced to government error, misrepresentation or inaction on enrollment, premium collection or termination of entitlement; and

C. Evidence of the error - Usually the headquarters file will show evidence that an error has occurred, e.g., delay in awarding coverage, an erroneous

termination, failure to deduct or bill for premiums. It is also possible that an individual may allege that his or her rights were prejudiced due to misinformation that was received. Such allegations must be substantiated. Equitable relief may not be granted in this situation unless there is documentary evidence in the form of statements from employees, agents or persons in authority that the alleged misinformation, misadvise, misrepresentation, inaction or erroneous action actually occurred, or that there is a strong likelihood based on personal knowledge or prior experience that it occurred.

Note: If equitable relief is being considered because a beneficiary alleges that he or she received incorrect information or advice from an RRB field office or that an RRB field office erred in handling a request, the RRB claims representative identified as having given the misinformation must submit a statement explaining his or recollection of the event. If the employee cannot recall the interview or discussion, he or she should nevertheless report on the probability that she or she gave misinformation or incorrect advice to the individual. If the claims representative cannot be identified for any reason, the district manager should report on the likelihood of such an error. The statement should be submitted to the Medicare Section.

EXCEPTION: If the individual caused or contributed materially to the government error by fraud or similar fault, equitable relief will not be granted even if the above three factors are present in the case.

810.35.2 Common Situations Involving Equitable Relief

A. Enrollment not processed timely - For a variety of reasons involving government fault or error, an individual's SMI enrollment request may not be processed until several months or years after coverage should have started. Similarly, there may be a delay of several months or years in notifying the enrollee that coverage has been awarded.

Serious inequity is likely to result where such an individual is required to pay for a long period of retroactive coverage which he or she may not have known existed; the individual may have continued to carry nongovernmental health insurance, or the individual may have deferred necessary treatment because he or she did not know they were insured for the cost of such treatment, and/or the individual may be unable to pay the premiums which accumulated over a long period of months or years.

1. Enrollment processed or enrollee notified 6 months or more after coverage should have started - If an enrollment request is filed timely but not processed, or the enrollee is not notified of the start of his coverage within the first 6 months after coverage should have started, the individual is enrolled effective with the month final

action is taken to process the award. Months elapsing after the end of the enrollment period in which the request was filed (or deemed to have been filed) will not be counted in determining the premium rate. The enrollee will be sent a special notice of SMI award, informing him or her of the option of having SMI coverage begin earlier (the date coverage would have started if the enrollment request were handled timely), provided that within 30 days he or she (l) requests the earlier date of coverage, and (2) either pays all back premiums due for months of coverage prior to the month shown on the award notice, authorizes deduction of the back premiums from monthly benefit payments or arranges for an alternate method of payment.

If the individual selects the earlier effective date and arranges to pay all back premiums, the Medicare Section will adjust the HI record to show the earlier date of coverage. The Medicare Section should then determine whether it is necessary to alert the enrollee to the need for prompt filing of Part B claims for any covered services he or she may have received during the first months of SMI entitlement. If the time limit for filing claims for services received in the first months of coverage has ended, or will end within 6 months after the beneficiary is informed of the earlier coverage date, the enrollee is advised that claims for such services will be honored if filed within 6 months after the month he or she is notified.

If the enrollee has already made it clear that he or she wants only current coverage or wants (and is willing to pay for) earlier entitlement, SMI coverage is awarded accordingly without providing notice of coverage date options.

These procedures also apply when an application for enrollment was denied initially for any reason, and as a result of reconsideration or a hearing, the original decision is reversed.

2. <u>Enrollment not processed but premium deductions in force - enrollee not notified until 6 or more months after coverage should have started</u> - It is possible, especially in the case where only an SS benefit is being paid, that premium deductions were initiated timely but the necessary enrollment activities were omitted. In such cases, the enrollee may or may not know about the deductions. Since no valid enrollment has been processed, claims for benefits could not be filed. It is possible that the individual is aware that deductions are being made, but that he simply has not yet had a claim to file.

In such cases, the individual is enrolled effective with the date deductions began. The individual is notified by Headquarters of the effective date of coverage. If the enrollee spontaneously objects within 2 months after the month in which he is notified of his coverage, the SMI award may be reversed. Any premiums collected should be refunded and the individual will be deemed not to have enrolled or, in automatic enrollment cases, will be deemed to have refused enrollment. If he desires SMI, but does not wish to accept coverage effective with the earlier date when deductions began, Headquarters advises him of the next general enrollment period. The beneficiary cannot accept an intermediate effective date of coverage. If the beneficiary declines coverage effective with when the deductions began, he may suffer a premium penalty if he enrolls in a later GEP.

3. Individual dies before award is made - If a SMI award is delayed so that notice of the choice in A. or B. above could not be made by the individual prior to his death, any of his survivors can be given the option of electing SMI as of the date entitlement should have begun and paying the premiums, or refusing SMI entirely. If an amended award, which would cause earlier SMI entitlement is made to a person who already has SMI but the enrollee dies before he is able to make the choice of having earlier SMI entitlement, the survivors can be given the choice of accepting the new (earlier) SMI entitlement date and paying the additional premiums or refusing earlier entitlement.

B. SMI awarded on later of 2 timely enrollment requests - After a person has been awarded SMI on the basis of an enrollment request, an examiner may discover an earlier, timely enrollment request, still unprocessed. If we revised the existing SMI award to change the effective date to one that would be consistent with the earlier enrollment request, the enrollee could be required to pay for many months of undesired SMI coverage. Such action would likely result in complaints of hardship and inequity.

A case involving an unprocessed earlier request for a person currently enrolled will be handled as follows:

1. The enrollee's premium rate is reduced, if necessary, to be consistent with the enrollment period in which the earlier request was filed. Any excess premium amounts already collected will be refunded or used as a credit against any future premium liability. The enrollee is notified that his prior premium rate had been incorrectly computed, and that the error has been corrected. No field office action is necessary.

2. However, if the file reflects a current or timely protest (filed within 6 months of notice) against the existing SMI award, the Medicare Section will notify the enrollee that he may have his SMI coverage begin at the earlier date provided that within 30 days he so elects and pays the retroactive premiums which have accrued, authorizes the deduction of such premiums from his monthly payments or arranges an alternative method of payment.

C. Delayed or incorrect advice frustrates enrollment or termination rights - In some cases, an individual may be prevented from taking timely and appropriate action to enroll for or terminate SMI coverage due to administrative delay or misadvise. For example, an individual may write to the RRB shortly before or during an enrollment period open to him, but be prevented from enrolling because we did not answer his inquiry until most or all of the enrollment period had elapsed. Relief in such cases will be provided to insure that the enrollee's desires are met. Similar relief is provided in cases where an enrollee inquires about SMI termination and a reply is not given in time to permit him to file a voluntary termination request within the same calendar quarter in which he inquired about termination.

Cases of this type are to be handled as follows:

1. Inquiry shows unequivocal desire to enroll - When an individual inquires about SMI during or within 9 months prior to the start of an enrollment period open to him, and from the nature of the inquiry it is clear that he wants SMI, he should be awarded coverage based on filing on the first day of that period. However, if taking action to provide such relief would result in the award of 6 or more months of retroactive coverage, SMI is awarded beginning with the month in which the individual is notified. The individual is informed of his right to obtain earlier coverage by requesting such coverage and paying the accrued premiums.

2. Inquiry does not show unequivocal desire to enroll - If the inquiry does not express a clear and unequivocal desire to enroll, the individual will be mailed an enrollment card (Form G-44) and a letter informing him that he may obtain coverage as of the date his coverage would have started if we had promptly replied to his inquiry. The letter explains that he may only have the earlier date of coverage if within 30 days he completes Form G-44 and returns it with a premium payment, if no benefits are currently payable. If the Form G-44 is returned promptly, he will be deemed to have filed his enrollment request timely. Otherwise, he must file during the next GEP.

D. SMI awarded erroneously - In some cases, after an individual has been enrolled, new evidence may be discovered indicating that SMI should have been disallowed; e.g., the individual had not yet attained age 65, or had not filed his enrollment request during an enrollment period open to him. Ordinarily, the individual will wish to retain his SMI because he may have given up his non- governmental health insurance or incurred substantial medical expenses in reliance on the SMI award. These erroneous SMI awards are handled in accordance with l and 2 below.

EXCEPTION: If an individual erroneously awarded SMI makes a timely protest against enrollment (i.e., before his SMI entitlement begins, or if later, within 6 months after the month in which he is notified of his SMI entitlement), the erroneous period of SMI coverage is deleted from the health insurance records, and any premiums paid refunded provided he repays any SMI benefits paid pursuant to the erroneous enrollment.

1. Error discovered in or after actual IEP - If the error is discovered after the start of the individual's actual IEP, the SMI award will not be disturbed unless it was procured through fraud or similar fault of the individual. If it is determined that there was fraud or similar fault, equitable relief will not be granted, the SMI award will be annulled, and any Part B payments made during the period of erroneous entitlement will be treated as overpayments.

2. Error discovered before the actual IEP - If fraud is not involved and an individual was enrolled erroneously and the error is discovered before the start of his actual IEP, HI and SMI coverage will be canceled with the last day of the month in which the action is taken. The Medicare Section will notify the individual of the reason for the cancellation, and of the time when he may again enroll. No refund of premiums or recovery of payments due to utilization is made in this circumstance.

E. SMI terminated erroneously - When an individual's SMI coverage is terminated erroneously, he is in approximately the same situation as the person whose enrollment was not processed timely. That is, he does not know whether he has SMI or not; he may enroll in a nongovernmental health plan to assure some protection for his medical expenses; he may defer necessary treatment because of his uncertainty about being insured against the cost of such treatment, etc. When the error is finally corrected, it would be unfair to reinstate his entitlement retroactively and require him to pay premiums for past SMI coverage that he had been unable to use at the time. Accordingly, the options offered to the individual whose enrollment was not processed timely are also offered to the individual whose SMI was terminated erroneously, if 6 months or more premiums are owed.

1. Error discovered 6 or more months after termination - When 6 months or more premiums are owed, individuals are given the same kind of option for termination as given in late enrollment cases.

   If the individual pays in full, authorizes withholding of the full amount from his monthly payments or agrees to monthly installments coverage is reinstated as of the month of the erroneous termination. If necessary, MS alerts the enrollee to the need for filing his claims promptly based on any SMI services on which the ordinary deadline for filing may have passed or be within 6 months of the month of reinstatement.

   If the enrollee has already made it clear that he wants only prospective coverage or that he wants (and is willing to pay for) coverage during the retroactive period, SMI is reinstated accordingly without mentioning the option, providing he is willing to pay the premium arrearage.

   If the enrollee protests that he does not want SMI coverage and such protest is filed within 2 months after the month in which he is notified that his coverage was reinstated, the SMI reinstatement is reversed (i.e., the original termination is permitted to stand) and any premiums collected are refunded.

2. Error discovered less than 6 months after month of termination - If an erroneous termination is discovered less than 6 months after the effective month of termination, no relief from premium liability may be granted. Action is taken to reinstate SMI coverage and collect past premiums due as soon as possible. If the enrollee spontaneously protests, the Medicare Section will offer alternative methods of recovery.

F. Inadvertent failure to bill for or deduct premiums - non-buy-in cases - In some cases, long after a person has been awarded SMI and notified of his or her SMI coverage, it is learned that premiums have inadvertently not been billed or deducted from benefit payments for a period of months or years. By the time premium collection is initiated or resumed, the individual may have difficulty in paying the arrearage, especially in a lump-sum. To avoid hardship or the necessity of terminating SMI in cases where premium arrearages accumulated because of administrative error, relief may be provided as follows:

   1. Premium arrearage of 6 months or more - When premiums are due for 6 months or more, and monthly RR or SS payments are in current pay status, the Medicare Section releases a notice to the enrollee explaining the arrearage and the proposed method of

recovery (cash refund or full withholding). If the enrollee does not request any relief options offered by the notice within 30 days, the Medicare Section will take recovery action. However, if a request for relief is received after 30 days, it will still be honored.

2. Premium arrearage of less than 6 months - Where the premium arrearage is not substantial, payment of the amount owed within the usual grace period will not normally create undue hardship for the enrollee. Therefore, no advance offer of waiver is given where SMI premiums are due for 5 or fewer months of coverage.

   Although no mention of waiver is made in the arrearage letter in these situations, if the enrollee spontaneously complains of hardship the Medicare Section will not recover the arrearage. If payments have already been suspended, they are to be reinstated and waiver development initiated.

3. Premium arrearage due to IRMAA, penalty surcharge, or Medicare Advantage Part B premium reduction – In cases involving a premium arrearage that is the result of retroactive changes in the amount of a Part B premium because of (1) the addition of or a change in an Income Related Monthly Adjustment Amount (IRMAA), (2) the imposition of a premium surcharge, or (3) a change in a Medicare Advantage premium reduction, equitable relief will automatically be considered if the amount of the arrearage exceeds 5 times the current standard Part B premium. Exception: When the premium arrearage is due to IRMAA, the amount must exceed 5 times the current standard Part B premium plus the amount of the individual's IRMAA.

   Note that the determining factor in these situations is the amount of premiums due, not the number of months for which an adjustment to the premium is due. See RCM 3.2.108 and RCM 3.2.109 for additional details and examples of equitable relief for beneficiaries subject to IRMAA and equitable relief in cases involving Medicare Advantage Part B premium reductions.

   Note: Automatic consideration of equitable relief in these types of cases generally means that the initial notice that premiums are due explains the options to pay by installment and to request waiver of payment of the premiums if payment would cause financial hardship. Cancellation of Part B coverage for the months for which additional premiums are due cannot be considered.

4. Collection of current premiums - To prevent a premium arrearage from increasing while development is under way to establish an installment payment schedule, or to determine whether payment of

the arrearage can be waived, the enrollee should pay for current coverage.

5. When relief from premium liability will be considered and granted - Many individuals, while willing and able to pay current premiums by deduction from monthly benefits or by direct remittance, may not have the resources to pay the premium arrearage even in minimum monthly installments of $20.00.

   As explained above, if the arrearage is for 6 months or more, upon resumption of billing or premium deductions the individual will be notified about the possibility of waiver. Likewise, waiver will be considered even for individuals with smaller arrearages if they request it or complain that it would be a hardship to pay the arrearage. The same criteria will be applied in determining whether waiver can be granted, regardless of whether the arrearage is 6 months or less.

   Where 6 months or more of retroactive premiums are owed, only the premiums for current coverage are deducted or billed immediately. The arrearage is not recovered until 30 days after the enrollee has been notified of the arrearage to give him the opportunity to claim hardship.

   If the beneficiary requests waiver, the field office will be requested to obtain a completed Form DR-423.

   The individual should be relieved of the obligation to pay an arrearage of premiums caused by governmental fault if payment of the amount would deprive him or her of funds which are reasonably necessary for ordinary living expenses. This is the same test used in determining whether recovery of an annuity overpayment would defeat the purpose of title II of the Social Security Act. The Division of Debt Recovery (DRD) will determine whether the arrearage situation meets the criteria for waiver and will so notify the enrollee. Authority to provide waiver is contained in section 7(d) of the Railroad Retirement Act and section 1837(h) of the Social Security Act. If the waiver request must be denied, DRD advises the individual that installment payments or partial withholding are still permissible.

G. Delayed deletion from state buy-in rolls results in premium arrearage - An individual whose state buy-in coverage terminates is deemed to be individually enrolled with continuing coverage and premium liability from the month after the month in which his buy-in coverage terminates. In some cases, because of program delays, 4 or more months may elapse

between the end of the buy-in coverage and initiation of premium collection.

Such individuals are not required to pay more than 3 months of premium arrearage. Most state buy-in deletions are handled mechanically and relief is automatically given to anyone owing 4 or more months of retroactive premium (i.e., deductions or billing will be made for only 3 retroactive months and the current month).

When a premium arrearage of 2 or 3 months will be recovered, no special advance notice is sent to the beneficiary. However, if the individual spontaneously complains that he or she cannot afford to pay 1, 2 or 3 months retroactive premiums, it is possible to grant relief from even the 3 months arrearage. The district office will be requested to secure Form DR-423 from the beneficiary. "Hardship" cannot be assumed without this development, because the individual's loss of state buy-in presupposes an improvement in the beneficiary's financial status.

The Division of Debt Recovery (DRD) will determine whether the arrearage situation meets the criteria for waiver and will so notify the enrollee. If the waiver request must be denied, DRD will advise that installment payments and partial withholding are still permissible.

H. Delayed deletion from state buy-in rolls prejudices termination rights - Persons who wish to terminate their individual SMI coverage after state buy-in coverage ends, face the same disadvantages if delayed deletion occurs, as those beneficiaries who choose to continue coverage. See FOM-1-810.40.2.

By law, the states may terminate buy-in coverage as early as 2 months prior to the month they actually report to CMS that a specific individual has been deleted from the buy-in rolls. Each month, CMS furnishes RRB a tape of that month's accretion and deletion activity.

Because of administrative delays, several months may have elapsed between the date of the state's deletion and the date the individual is notified of the deletion. Such an individual would technically owe premiums for the elapsed months. The law was not intended to penalize such individuals who had no opportunity to request termination during the last month they were covered by the state. Therefore, if an individual was not advised by the state of the deletion in or before the month of deletion, equitable relief can be granted. This allows an individual's SMI coverage to end effective with the termination of buy-in coverage (thus allowing him or her to avoid entirely any premium liability), if all the following conditions are met:

1. The individual submits a written request to have his or her individual SMI coverage end effective with the end of state buy-in coverage.

2. Such request is filed within 30 days of the date of the notice informing the beneficiary that the state is no longer paying premiums.

3. The individual certifies that he or she has incurred no medical services covered under SMI during the months after buy-in termination.

   If an individual did receive medical services covered under SMI after the end of buy-in coverage, his or her individual entitlement must continue until the end of the month in which the termination request is filed (if the request is filed within 6 months of buy-in termination). No intermediate date may be selected for the termination effective date.

I. SEP enrollment under equitable relief provisions – In certain cases, a disabled beneficiary may decline Part B coverage because his or her Group Health Plan (GHP) or Large Group Health Plan (LGHP) may erroneously assume the role of primary payer, even though the GHP/LGHP coverage is not based on a current employment status. This mistake may not be identified until the GHP/LGHP coverage terminates, or the employer otherwise identifies the mistake. Under the equitable relief provisions, a disabled individual who was misinformed (or not informed) about whether the GHP/LGHP was the primary payer may enroll in Medicare during a disability special enrollment period (D-SEP). The D-SEP, for beneficiaries who qualify under this situation, are entitled to a 7-month period beginning the later of:

   - The date of the notice from the employer advising that the GHP/LGHP is no longer the primary payer, or

   - The last month for which the GHP/LGHP is the primary payer of benefits.

   If there is proof, or the likelihood, that misinformation (including no information) was provided by an employee of the Federal government, the employer, or the GHP/LGHP, equitable relief may be granted to correct the results of the unjust situation. In general, you can consider that the beneficiary was misinformed if the GHP/LGHP continued to provide coverage as the primary payer even though the beneficiary, spouse, or family member no longer had a current employment status. Premium surcharges can be waived or reduced, and a special enrollment period granted.

   As a result of the repeal of the Defense of Marriage Act (DOMA) on June 26, 2013, we are now able to process premium surcharge rollback request

actions for individuals who enrolled in the GEP, but had GHP or LGHP coverage based on current employment of a same-sex spouse. Same-sex marriages are treated the same as opposite-sex marriages for purposes of the premium surcharge rollback.

Certain SEP requests filed after the 8-month SEP ended may be approved if all of the following criteria are met:

- The individual filed a SEP request for SMI after October 2012 and was denied.
- The SEP for the individual must end within the months of June 2013 through April 2014.
- The second SEP request is received prior to June 2014.
- The first denial was based on the existence of a same-sex marriage due to the application of Defense of Marriage Act (DOMA) rules and all other eligibility criteria were met.

Give the individual the option to have the date of entitlement be based on the month of the first or the second filing.

Beneficiaries age 65 or older or under age 65 and covered under a GHP based on the current employment status of a domestic (or life) partner are not spouses for SEP and premium surcharge rollback purposes. However, under the equitable relief provisions, these beneficiaries are permitted to enroll in Part B as if the SEP provisions still apply. Grant equitable relief to the following individuals who:

- Refused Part B and whose initial enrollment period (IEP) begins 12/2004 or earlier; or

- Enrolled in Part B during the IEP and voluntarily terminated coverage prior to 12/2004.

1. **Background** - An individual may have one or more types of health insurance or coverage in addition to Medicare. The terms “primary payer” and “secondary payer” refer to who pays health insurance costs first. Depending on the circumstances, Medicare may be the primary or secondary payer on a health insurance claim.

   The Omnibus Budget Reconciliation Act of 1993 (OBRA-1993) made Medicare the secondary payer for a disabled beneficiary covered by a LGHP based on the current employment status of the individual or a family member. For individuals who do not have LGHP coverage based on their own current employment status or the current employment status of a family member, OBRA-1993 made Medicare the primary payer of benefits.

Note: Because individuals may not have previously enrolled in Medicare Part B, OBRA-1993 allowed them to enroll during what was supposed to be a one-time disability special enrollment period (D-SEP).

A disabled beneficiary might decline enrollment in Medicare Part B when first eligible because his or her GHP/LGHP is the primary payer of benefits. When coverage under the GHP/LGHP ends, the beneficiary then wants to enroll for Part B during a SEP. In many cases, however, there is a problem. The individual is not eligible for a SEP under the regular provisions because his or her GHP/LGHP coverage is not based on a current employment status.

CMS has a process by which employers are to notify disabled individuals when the GHP/LGHP is no longer the primary payer of benefits. However, many employers continue to provide GHP/LGHP coverage as the primary payer after there is no longer a current employment status

2. **Evidence Requirements** The individual may enroll or re-enroll in SMI under the equitable relief provisions if he or she submits a letter from the employer or other documentation that shows:

   - The GHP/LGHP has been primary payer of benefits for some period of time in or after January 1987;
   - The GHP/LGHP should not have been primary payer; and
   - The GHP/LGHP stopped (or will stop) making primary payments as of a specified date.

   The employer should complete Form RL-311-F, clearly showing the beginning and ending dates of the GHP/LGHP coverage. Form RL-311-F is not required if Form G-44B is submitted with correspondence from the employer of the GHP/LGHP that clearly shows all of the information requested on Form RL-311-F, including the dates that the individual was covered by the GHP/LGHP. If documentation cannot be obtained from the employer concerning the dates of GHP/LGHP coverage and the change in status as primary payer of benefits, the beneficiary must submit a statement providing as much of the information as possible.

3. **Enrollment Requirements** The individual must enroll within 7 months of:

   - The date of the notice from the employer advising that the GHP/LGHP is no longer the primary payer, or
   - The last month for which the GHP/LGHP is the primary payer of benefits.

Obtain Form G-44B from the individual. In item 7 (Remarks), the applicant should indicate that he or she wants to enroll under the equitable relief provisions, and provide an explanation as to what misinformation he or she received and who provided the misinformation.

The Form G-44B, Form RL-311-F, and any correspondence that support the applicant's request to file under the equitable relief provisions, should be imaged. It is no longer necessary to mail the documentation to the Medicare Section.

NOTE: If Form G-44B is received without Form RL-311-F or supporting correspondence, pend for receipt of the latter two before imaging. When all documents are received, scan them together as a multi-page document. Headquarters staff will index the package as form type, EmployerSEP Ltr.

4. **SMI Effective Date** The SMI effective date for a beneficiary who files for SMI during a D-SEP is:

   - The first day of the month of enrollment in SMI, or

   - The first month the GHP/LGHP is no longer primary payer. The beneficiary must agree to pay all premiums due, if applicable.

5. Examples:

- Employee A last worked for the Patapsco and Back Rivers Railroad in March 1991, and began receiving a disability annuity in September 1991. He was enrolled in Medicare Part A effective September 1993, but declined Part B coverage because he had LGHP coverage through Bethlehem Steel, the railroad's parent company. The LGHP continued to provide coverage as the primary payer even after the change in law (OBRA-1993).

  On March 25, 2003, Employee A was notified that his LGHP coverage would end March 31, 2003, because of the bankruptcy of Bethlehem Steel. Employee A contacted the RRB in July 2003 to apply for Part B coverage effective August 1, 2003. Because he applied within 7 months of the date that his LGHP coverage was terminated and was "misinformed," i.e. not properly informed that his LGHP coverage should have been the secondary payer under the OBRA-1993 provisions, he was granted a special enrollment period.

- Employee B last worked for the Union Pacific Railroad in September 1999, and began receiving a disability annuity effective March 1, 2000. He was enrolled in Medicare Part A effective March 2002, but

declined Part B because he was covered under the Union Pacific's Long Term Disability (LTD) Plan, administered by United HealthCare.

Although Employee B did not have a current employment status, the LTD Plan continued to provide coverage as the primary payer until 2003. On September 9, 2003, Employee B was notified that, because he was eligible for Medicare on the basis of his disability, the LTD Plan would only provide secondary medical coverage effective January 2003. Employee B must contact the RRB within 7 months of the September 9, 2003 notice in order to be granted a special enrollment period to enroll for Medicare Part B coverage.

- Employee C attained age 65 in November 2004. He refused Part B coverage because he was covered under his domestic (or life) partner's group health plan (GHP). His partner, Mr. Smith, is working and the GHP includes domestic partner within the definition of spouse. In October 2011, Employee C contacts a field office about enrolling in Part B because his partner is retiring January 1, 2012. Since a domestic partner, age 65 or older, cannot be recognized as a spouse, the SEP provisions no longer apply. However, under the equitable relief provisions, Employee C may enroll in SMI during any month in which he has coverage under the GHP based on current employment or during the 8-month period that begins with the first full month after the GHP coverage based on current employment ends.

810.40 Termination

810.40.1 Termination of HI Coverage

A. Beneficiary under age 65 - Disability HI coverage, other than for end-stage renal disease ends the earlier of:

1. The day of death; or

2. The month before the month age 65 is attained; or

3. For a beneficiary who is not eligible for a trial work period (TWP), the month in which the disability benefit ends or if later the month after the month in which the notice of termination is mailed.

   Example: A determination is made that disability benefits are no longer payable to a beneficiary effective April 30, 2005 because his impairment is no longer disabling. If notice of the termination is mailed in February or March 2005, HI coverage ends at the same time the disability benefits end. If notice of the termination is not mailed until May 2005, HI coverage ends June 30, 2005.

If disability benefits stop because the beneficiary has substantial gainful activity (SGA) following a TWP, coverage may continue after the beneficiary's disability entitlement ends. In cases where disability benefits end because of SGA following a TWP, HI coverage ends as follows:

- If the beneficiary's disability ceases (the first month of SGA following the end of the TWP) prior to the 14th month of his or her re-entitlement period, also referred to as an extended period of eligibility (EPE), and he or she engaged in SGA in the 16th month of the EPE, HI coverage ends the last day of the 57th month following the end of the 36 month disability re-entitlement period or, if later, the end of the month following the disability termination notice.

  Example: A beneficiary has been entitled to HI based on disability since May 2000. Although he continues to be severely impaired, he completed a TWP in a sheltered workshop on September 30, 2001. He continues working at SGA levels, and his disability benefits are terminated effective December 31, 2001 (the end of the second month following the month his disability ceased) and his disability entitlement ends October 1, 2004 (the first month of SGA after the 36-month re-entitlement period ends). His HI coverage, however, continues through June 30, 2009, the last day of the 57th month following the end of his 36 month re-entitlement period.

- If the beneficiary's disability ceases prior to the 14th month of the EPE, but he or she does not engage in SGA in the 16th month of the EPE, HI coverage ends the last day of the 77th month following the first month of SGA occurring after the 16th month or, if later, the end of the month following the disability benefit termination notice.

  Example: A beneficiary has been entitled to HI based on disability since May 2000. He completes a TWP in a sheltered workshop on September 30, 2001. He continues working at SGA levels for 12 months, stops working until May 2003, and then resumes working at SGA levels. His disability benefits are terminated effective December 31, 2001 (the end of the second month following the month his disability ceased). His disability entitlement ends October 1, 2004 (the first month of SGA after his 36-month re-entitlement period ends). His HI coverage, however, continues through October 31, 2009, the last day of the 77th month following the first month of SGA after the 16th month of his re-entitlement period.

- If the beneficiary's disability ceases after the 13th month of the EPE, HI coverage ends with the last day of the 80th month following the month the disability ceases or, if later, with the end of the month following the disability benefit termination notice.

  Example: A beneficiary has been entitled to HI based on disability since May 2000. He completes a TWP on September 30, 2001, and begins a 36-month period of re-entitlement on October 1, 2001. His disability ceases in February 2003, when he is determined to have performed SGA in that month. Because his disability ceased after the 13th month of his re-entitlement period, his HI coverage continues through October 31, 2009, the last day of the 80th month following the month his disability ceased.

Note: If medical improvement or some other non-SGA terminating event occurs prior to the dates provided above, HI coverage ends the later of (1) the month in which disability benefits are terminated, or (2) the month after the month in which the benefit termination is mailed to the beneficiary.

Note: A beneficiary cannot voluntarily terminate HI (Part A) coverage. In order to withdraw from Part A, the beneficiary must withdraw his or her application for an annuity and repay all benefits received, including RRA and SSA payments and any benefits paid under Medicare.

B. Beneficiary age 65 or over - HI coverage ends with the day of death or when the person's eligibility for benefits under the Railroad Retirement Act and/or the Social Security Act ends. In case of death, protection continues through the month of death. However, a person over age 65 who no longer qualifies for benefits under either of the Acts may reinstate the HI protection if either of the following requirements are met.

1. Qualifies under the special transitional provision (FOM-1-810.5.3); or

2. Qualifies under the uninsured HI provision (FOM-1-810.5.4).

C. Premium HI beneficiary - Coverage under premium HI ends:

1. With the day of death;

2. The last day of the month following the month the beneficiary files a notice of voluntary termination with SSA;

3. The last day of the second month following the due date for premium payment if the premium is not paid;

4. On the date of termination of SMI coverage;

5. With the first month of eligibility for HI as an insured or deemed insured person at RRB or SSA.

810.40.2 Termination of SMI Coverage

SMI coverage may terminate for any of the following reasons: death of the enrollee, recovery from disability for persons under age 65, nonpayment of SMI premiums, voluntary termination. The effective date of termination in each instance is discussed below.

A. Death of enrollee - SMI coverage extends through the date of death.

B. Recovery from disability - SMI coverage ends with the later of:

- The last month of entitlement to a monthly disability benefit, or if later the month after the month in which the notice of termination is mailed. If disability benefits stop because the beneficiary is working, but the person has not recovered from his or her disability, coverage may continue after monthly disability benefits stop. See FOM-1-810.40.1.A.3).

- The month after the month the beneficiary is notified of the termination of benefits.

C. Non-payment of premiums - SMI coverage terminates at the end of the grace period provided for the payment of overdue premiums. Normally, the grace period for payment of premiums is the 90-day period following the month in which the bill is issued. The grace period may be extended for another 90 days if there was good cause for failure to pay the overdue premiums within the initial 90-day period.

D. Voluntary termination - Any beneficiary not covered under a state buy-in agreement may request termination of his or her SMI coverage at any time. A request for termination must be made in writing, unequivocally stating a desire to end SMI coverage, and signed by the enrollee. If the enrollee is incompetent, the statement may be signed by someone approved to act in his or her behalf. Form G-718, though not required, has been designed for this purpose.

Termination in these cases is effective with the last day of the month after the month in which the written notice is officially filed. (Prior to July 1, 1987, the effective date for dis-enrollment was the end of the quarter after the quarter the request was filed.) Premiums must be paid through the effective month of termination.

A signed statement from the beneficiary must be submitted to confirm the request to terminate Part B coverage. Be sure to stamp the date of receipt on the statement. Submit the signed statement with a brief memorandum (Form G-115) in a sealed white envelope addressed to: Operations-MS "Do not open in mailroom." The Medicare Section will terminate SMI coverage and release a confirmation letter to the beneficiary.

Note: Do not submit e-mails to the Medicare Section requesting Part B election changes for beneficiaries. The Medicare Section can take no action without the beneficiary's signed statement. The Medicare Section will, however, initiate action to terminate coverage based on a facsimile of the signed statement.

E. Voluntary termination following state buy-in deletion - If an individual's state buy-in coverage ends, the enrollee's SMI coverage continues as if he or she had filed in an IEP. If an individual desires to end SMI coverage after state buy-in deletion, he or she may do so by filing a written request as described above. See FOM-1-810.35.2).

Prior to 4-1-81, termination for those in current pay status was effective with the third month after the last month of buy-in coverage if the termination request was filed within that 3-month period. Those not in current pay status were terminated according to the rules for regular "voluntary termination;" i.e., termination was effective the last day of the calendar quarter after the quarter in which the written notice was officially filed.

Effective April 1, 1981, any individual whose state buy-in coverage has been terminated and who files a notice requesting termination of his individual SMI during the last month of buy-in coverage or during the 6 succeeding months will have his or her individual SMI terminated at the end of the month in which the notice was filed. Refer to FOM-1-810.35.2H for a further discussion of relief that may be offered.

810.45 Jurisdiction Of Coverage

The term "jurisdiction" is used in the Medicare program to indicate whether RRB or SSA is responsible for enrolling a person, issuing an ID card, and collecting premiums.

810.45.1 How Jurisdiction Is Determined

RRB has jurisdiction of the health insurance of all QRRBs and all persons whose SS benefits are paid by RRB ("deemed" QRRBs). However, an HI record will not be established until a QRRB or "deemed" QRRB files a railroad retirement or social security application. If SSA has jurisdiction when an HI record is initially

established, that agency will continue to have jurisdiction until the QRRB files a railroad retirement application or an inquiry is received and HI clearance is requested by RRB. At that time, HI jurisdiction is automatically transferred to RRB.

If an individual does not meet the definition of a QRRB and SS benefits are not payable at RRB, the RRB does not have jurisdiction. For example, SSA has jurisdiction over the health insurance of an employee with less than 120 service months or less than 60 service months after 1995, the disabled child of an employee who is under age 62 and not under a DF, or a survivor who elected an RLS. Once established at RRB, HI jurisdiction will generally not change as long as the person is a QRRB or SS benefits are payable at RRB.

810.45.2 Situations Which Cause Jurisdiction to Change from SSA to RRB

Medicare jurisdiction will be transferred from SSA to RRB when:

- A beneficiary who filed for and was entitled to Medicare coverage at SSA, files for and becomes entitled to an RR annuity.

  Exception: If Medicare coverage is based on the End Stage Renal Disease (ESRD) provision, coverage will not be transferred to RRB until the annuitant qualifies for coverage based on disability or a regular insured status

- A spouse, widow(er), surviving divorced spouse or remarried widow(er) receiving a DIB benefit and Medicare coverage at SSA attains age 65.

- An annuitant who had Medicare coverage at SSA based on one DOB, attains age 65 based on a later DOB established at RRB.

Although RRB has jurisdiction of Medicare coverage for all QRRBs, no special attempt will be made to obtain jurisdiction of QRRBs with Medicare coverage at SSA until an annuity is payable at RRB or until the attainment of age 65.

Note: In cases in which the RRB is paying the beneficiary's social security benefits (LAF E cases), Medicare jurisdiction will be established on RRB records based on information provided by SSA. This includes disabled spouses and cases involving ESRD.

810.45.3 Situations Which Cause Jurisdiction to Change from RRB to SSA

Medicare jurisdiction will be transferred from RRB to SSA when:

- A non-disabled applicant is at least 64 years and 9 months old but is not a QRRB or "deemed" QRRB;

- An annuitant, IPI or Medicare only enrollee who is not a "deemed" QRRB loses QRRB status (included are cases in which the employee dies and SSA has jurisdiction of survivor benefits, or a disabled child marries);
- A "deemed" QRRB is no longer entitled to SSA benefits; or
- A "deemed" QRRB is no longer entitled or potentially entitled to a railroad retirement annuity.

810.45.4 Where and What Type of Application to File

An individual who meets the eligibility requirements must file an application for Medicare alone or for retirement, survivor or disability benefits at the RRB or SSA or for inclusion as an IPI at the RRB. The following chart summarizes the type of application that may be filed and where it should be filed.

BENEFICIARY'S STATUS	ACTION REQUIRED TO ESTABLISH ENTITLEMENT TO MEDICARE
Not QRRB. Not insured at SSA.	Must file an application for Medicare only at SSA. Premiums will be paid directly to SSA.
Not QRRB. Insured at SSA.	Must file an application for Medicare only or for a benefit at SSA.
QRRB - Non-annuitant. Insured at SSA, but has not filed.	Must file an application for Medicare only or an application for benefits at SSA or at RRB.
QRRB - Non- annuitant. Insured at SSA and benefit certified to RRB (may be in suspense).	An application for Medicare only is not required. The beneficiary should be enrolled automatically by RRB. SSA certifies Medicare coverage to RRB when they transmit payment to us.
QRRB - Annuitant (may be in suspense) SSA status immaterial.	An application for Medicare only is not required. The beneficiary should be enrolled automatically.
QRRB - Filing for annuity in IEP, GEP or SEP, and not previously enrolled for Medicare; SSA status immaterial.	An application for Medicare only is not required. If the beneficiary is at least 64 years and 5 months of age and has not received an ID card, the question on the annuity application concerning SSA SMIB must be answered.
Victim of Chronic Renal Disease – QRRB status immaterial.	Must file an application for Medicare at SSA.