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

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

APPLICATION FOR ENROLLMENT IN MEDICARE PART B (MEDICAL INSURANCE)

1. Your Medicare Number
1JR4 – H88 – QT06

2. Your Name (Last Name, First Name, Middle Name)
Reinhart Victor Alan

3. Mailing Address (Number and Street, PO Box, or Route)
7462 Brian Ln

4. City
La Palma

State
CA

Zip Code
90623

5. Phone Number (Including Area Code)
(714) 309 – 7362

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

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

7b. Are you currently (or were you) an international volunteer for a non-profit organization and have or had health coverage provided to you? (If yes, complete 7c.) ☐ YES ☒ NO

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

Dates you (or your spouse) worked for employer that provided health coverage:	Dates of health coverage from employer (or non-profit organization):	Dates you worked as a volunteer outside the U.S.:
Start Date: 08/2019	Start Date: 08/2019	Start Date: /
Ending Date: /	Ending Date: /	Ending Date: /
Not ended ☒	Not ended ☒	Not ended ☐

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

9. Remarks: Please begin my Part B effective September 1, 2026.

10. Written Signature (DO NOT PRINT)
SIGN HERE Victor Reinhart

11. Date Signed
5 / 6 / 2026

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

12. Signature of Witness

13. Date Signed
/ /

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