

APPLICATION FOR ENROLLMENT IN MEDICARE PART B (MEDICAL INSURANCE)

1. Your Medicare Number

1 J R 4 - H 8 8 - Q T 0 6

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

C A

Zip Code

9 0 6 2 3

5. Phone Number (Including Area Code)

(7 1 4) 3 0 9 - 7 3 6 2

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:

Start Date: 0 8 / 2 0 1 9
Ending Date: /
Not ended ☒

Dates of health coverage from employer (or non-profit organization):

Start Date: 0 8 / 2 0 1 9
Ending Date: /
Not ended ☒

Dates you worked as a volunteer outside the U.S.:

Start Date: /
Ending Date: /
Not ended ☐

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

9. Remarks:

10. Written Signature (DO NOT PRINT)

SIGN HERE

Victor Reinhart

11. Date Signed

5 / 6 / 2 0 2 6

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)