

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

1. Your Medicare Number

1EG4-TE5-MK73

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

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

Parker, Peter, Harry

4. Mailing Address (Number and Street, P.O. Box, or Route)

3848 Overland Ave.

5. City

Culver City

State

CA

Zip Code

90232

6. Phone Number (including area code)

(310) 204-4345

7. Written Signature (DO NOT PRINT)

SIGN HERE

Peter Parker

8. Date Signed

02 / 22 / 2023

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

9. Signature of Witness

(any)

10. Date Signed

02 / 22 / 2023

11. Address of Witness

2911, Elm Ave, Manhattan Beach, California, 90266

12. Remarks

I have heart and lung disease. Please help me.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1230. The time required to complete this information is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.