

SOCIAL SECURITY ADMINISTRATION

STATEMENT OF CLAIMANT OR OTHER PERSON

NAME OF WAGE EARNER, SELF-EMPLOYED PERSON, OR SSI CLAIMANT	SOCIAL SECURITY NUMBER
NAME OF PERSON MAKING STATEMENT (If other than above wage-earner, self-employed person, or SSI claimant)	RELATIONSHIP TO WAGE-EARNER, SELF-EMPLOYED PERSON, OR SSI CLAIMANT

Understanding that this statement is for the use of the Social Security Administration, I hereby certify that Medicare is a two part program consisting of Hospital Insurance Benefits (HIB) and Supplementary Medical Insurance (SMIB). When an entitled beneficiary reaches age 65, or had been receiving disability benefits for 24 months, beneficiary will become automatically enrolled in HIB for free. In most cases, medical expenses incurred outside the U.S. are not reimbursable. The beneficiary must enroll for SMIB, but he must pay a monthly premium. Unless you intend to return to the United States for medical treatment, it would appear that enrolling for SMIB would be disadvantageous to you since you would be paying for a service which you could not receive. Please answer the following:

1. Do you understand that medical insurance does not cover medical expenses incurred outside the United States? YES _____ NO _____
2. Understanding the above, { I do, I do not } wish to apply for the Medical Supplemental Insurance Plan.

I know that anyone who makes or causes to be made a false statement or representation of material fact in an application or for use in determining a right to payment under the Social Security Act commits a crime punishable under the Federal law and/or State law. I affirm that all information I have given in this document is true.

SIGNATURE OF PERSON MAKING STATEMENT

SIGNATURE (First name, middle initial, last name)(Write in ink)

SIGN

HERE ⇨

Date (Month, day, year)

Telephone Number

Mailing Address (Number and street, Apt. No., P.O. Box, Rural Route)

City and State

ZIP Code

Witnesses are required ONLY if this statement has been signed by mark (X) above. If signed by mark (X) two witnesses to the signing who know the individual must sign below, giving their full addresses).

1. Signature of Witness

2. Signature of Witness

Address (Number and street, City, State, and ZIP Code)

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