APPLICATION FOR ENROLL	MENT IN MEDICARE PART B (MEDICAL INSURANCE)
. Your Social Security Claim Number	Beneficiary Identification Code (BIC)
. Do you wish to sign up for Medicare Part	B (Medical Insurance)? YES
. Your Name (Last Name, First Name, Midd	le Name)
. Mailing Address (Number and Street, P.O.	. Box, or Route)
. City	State Zip Code
Phone Number (including area code)	
. Written Signature (D-O NOT PRINT)	8. Date Signed
IGN HERE	
. Signature of Witness	PPLY THE INFORMATION REQUESTED BELOW.  10. Date Signed        /     /
1. Address of Witness	
2. Remarks	
. Phone Number (including area code)	And S
. Written Signature (DO NOT PRINT)	8. Date Signed
IGN HERE	
	SIGNED BY MARK (X), A WITNESS WHO KNOWS THE APPLICANT PPLY THE INFORMATION REQUESTED BELOW.
. Signature of Witness	10. Date Signed
1. Address of Witness	
2. Remarks	

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**PT Brinkman** 

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