09/2016

Form Approved
OMB No. 0938-1213

# Application for Health Coverage

## Apply faster online at HealthCare.gov

### Who can use this application?

Anyone who needs health coverage can use this application.

If someone is helping you fill out this application, you may need to complete Appendix C.

### What happens next?

Send your complete, signed application to the address on page 4. **If you don't have all the information we ask for, sign and submit your application anyway.**

We'll follow up with you within 1–2 weeks and you may receive a call from the Marketplace if we need more information. You'll get an eligibility determination notice in the mail after your application is processed.

Filling out this application doesn't mean you have to buy health coverage.

### Get help with costs

**You need to use a different application to get help with costs.** You could qualify for:

- A tax credit that can immediately help pay your premiums for health coverage
- Free or low-cost coverage from Medicaid or the Children's Health Insurance Program (CHIP)

**You may qualify for a free or low-cost program even if you earn as much as $97,200 a year (for a family of 4).** Visit HealthCare.gov or call the Marketplace Call Center to learn more.

### Get help with this application

- **Online:** HealthCare.gov.
- **Phone:** Call the Marketplace Call Center at **1-800-318-2596**. TTY users should call **1-855-889-4325**.
- **In person:** There may be counselors in your area who can help. Visit HealthCare.gov, or call the Marketplace Call Center at **1-800-318-2596** for more information.
- **En Español:** Llame a nuestro centro de ayuda gratis al **1-800-318-2596.**
- **Other languages:** If you need help in a language other than English, call **1-800-318-2596** and tell the customer service representative the language you need. We'll get you help at no cost to you.

You have the right to get the information in this product in an alternate format. You also have the right to file a complaint if you feel you've been discriminated against. Visit www.cms.gov/about-cms/agency-Information/aboutwebsite/cmsnondiscriminationnotice.html, or call the Marketplace Call Center at **1-800-318-2596** for more information. TTY users should call **1-855-889-4325**.

**PRA Disclosure Statement:** 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 0938-1191. The time required to complete this information collection is estimated to average 20 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 comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

**Please print in capital letters using black or dark blue ink only.**
**Fill in the circles ( ◯ ) like this → ●.**

# STEP 1: Tell us about yourself.

(We need one adult in the family to be the contact person for your application.)

1. First name | Middle name | Last name | Suffix

2. Home address (Leave blank if you don't have one.) | 3. Apartment or suite number

4. City | 5. State | 6. ZIP code | 7. County, parish, or township

8. Mailing address (if different from home address) | 9. Apartment or suite number

10. City | 11. State | 12. ZIP code | 13. County, parish, or township

14. Daytime phone number ___ ___ - ____

15. Evening phone number ___ ___ - ____

16. Do you want to get information about this application by email? ◯ Yes ◯ No

Email address:

17. What's your preferred spoken language? What's your preferred written language?

18. **Do you need health coverage for yourself?**

◯ **YES. If yes**, answer all the questions below. ◯ **NO. If no,** skip to Step 2 on page 2. (Leave the rest of this page blank)

19. Social Security Number (SSN) ___ - ___ - ____

**We need a Social Security number (SSN) if you want health coverage and have an SSN or can get one.** We use SSNs to check income and other information to see who's eligible for help paying for health coverage. If you need help getting an SSN, visit **socialsecurity.gov**, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.

20. Sex ◯ Male ◯ Female

21. Date of birth (mm/dd/yyyy) ___ / ___ / ____

22. Are you a **U.S. citizen** or **U.S. national**? ◯ Yes ◯ No

23. Are you a **naturalized** or **derived citizen**? *(This usually means you were born outside the U.S.)*

◯ **YES. If yes,** complete a and b. ◯ **NO. If no,** continue to question 24.

a. Alien number:

b. Certificate number:

After you complete a and b, SKIP to question 25.

24. **If you aren't a U.S. citizen or U.S. national,** do you have eligible immigration status? ◯ **YES.** Enter document type and ID number. *See instructions.*

Immigration document type | Status type (optional) | Write your name as it appears on your immigration document.

Alien or I-94 number | Card number or passport number

SEVIS ID or expiration date (optional) | Other (category code or country of issuance)

**Optional:** *(Fill in all that apply.)*

**25. If Hispanic/Latino, ethnicity:** ◯ Mexican ◯ Mexican American ◯ Chicano/a ◯ Puerto Rican ◯ Cuban ◯ Other _____

**26. Race:** ◯ White ◯ Black or African American ◯ American Indian or Alaska Native ◯ Filipino ◯ Japanese ◯ Korean ◯ Asian Indian ◯ Chinese ◯ Vietnamese ◯ Other Asian ◯ Native Hawaiian ◯ Guamanian or Chamorro ◯ Samoan ◯ Other Pacific Islander ◯ Other _____

## NOW, tell us who else needs health coverage.

## STEP 2: Tell us about anyone who needs health coverage.

(If you have more people to include, make a copy of this page and attach.)

### Person 2

1. First name | Middle name | Last name | Suffix

2. Relationship to PERSON 1?

3. Social Security Number (SSN) ___ - ___ - ____

4. Date of birth (mm/dd/yyyy) __ / __ / ____

5. Sex ◯ Male ◯ Female

6. Does PERSON 2 live at the same address as PERSON 1? ◯ Yes ◯ No

**If no,** list address:

7. Is PERSON 2 **U.S. citizen** or **U.S. national**? ◯ Yes ◯ No

8. Is PERSON 2 a **naturalized** or **derived citizen**? *(This usually means they were born outside the U.S.)*

◯ **YES. If yes,** complete a and b. ◯ **NO. If no,** continue to question 9.

a. Alien number:

b. Certificate number:

After you complete a and b, SKIP to question 10.

9. **If PERSON 2 isn't a U.S. citizen or U.S. national,** do they have eligible immigration status? ◯ **YES.** Enter document type and ID number. *See instructions.*

Immigration document type | Status type (optional) | Write PERSON 2's name as it appears on their immigration document.

Alien or I-94 number | Card number or passport number

SEVIS ID or expiration date (optional) | Other (category code or country of issuance)

a. Has PERSON 2 lived in the U.S. since 1996? ◯ Yes ◯ No

b. Is PERSON 2, or their spouse or parent, a veteran or an active-duty member of the U.S. military? ◯ Yes ◯ No

**Optional:** *(Fill in all that apply.)*

**10. If Hispanic/Latino, ethnicity:** ◯ Mexican ◯ Mexican American ◯ Chicano/a ◯ Puerto Rican ◯ Cuban ◯ Other _____

**11. Race:** ◯ White ◯ Black or African American ◯ American Indian or Alaska Native ◯ Filipino ◯ Japanese ◯ Korean ◯ Asian Indian ◯ Chinese ◯ Vietnamese ◯ Other Asian ◯ Native Hawaiian ◯ Guamanian or Chamorro ◯ Samoan ◯ Other Pacific Islander ◯ Other _____

## STEP 3: American Indians/Alaska Natives

American Indians and Alaska Natives can get services from the Indian Health Service, tribal health programs, or urban Indian health programs. They also may not have to pay cost sharing and may get special monthly enrollment periods. Answer the questions below to make sure your family gets the most help possible.

1. **Are you or is anyone in your family American Indian or Alaska Native?**

◯ **NO. If no,** continue to Step 4. ◯ **YES. If yes,** continue. If you have more people to include, make a copy of this page and attach.

2. Name (First name, Middle name, Last name)

3. Member of a federally recognized tribe? ◯ Yes ◯ No

**If yes,** Tribe name: | State tribe is located in: __

## STEP 4: Your agreement & signature

**Is anyone applying for health insurance on this application incarcerated (detained or jailed)?** ◯ Yes ◯ No

**If yes**, tell us the person's name. The name of the incarcerated person is:

◯ Fill in here if this person is facing disposition of charges.

- I'm signing this application under penalty of perjury, which means I've provided true answers to all the questions on this form to the best of my knowledge. I know that I may be subject to penalties under federal law if I intentionally provide false or untrue information.
- I know that I must tell the Health Insurance Marketplace within 30 days if anything changes (and is different than) what I wrote on this application. I can visit **HealthCare.gov** or call **1-800-318-2596** to report any changes. I understand that a change in my information could affect my eligibility as well as eligibility for member(s) of my household.
- I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting **www.hhs.gov/ocr/office/file**.
- I know that information on this form will be used only to determine eligibility for health coverage, help paying for coverage (if requested), and for lawful purposes of the Marketplace and programs that help pay for coverage.

We need this information to check your eligibility for health coverage. We'll check your answers using information in our electronic databases and databases from the Internal Revenue Service (IRS), Social Security, the Department of Homeland Security, and/or a consumer reporting agency. If the information doesn't match, we may ask you to send us proof.

### What should I do if I think my eligibility results are wrong?

If you don't agree with what you qualify for, in many cases, you can ask for an appeal. Please review your eligibility notice to find appeals instructions specific to each person in your household who applies for coverage, including how many days you have to request an appeal. Here's important information to consider when requesting an appeal:

- You can have someone request or participate in your appeal if you want to. That person can be a friend, relative, lawyer, or other individual. Or, you can request and participate in your appeal on your own.
- If you request an appeal, you may be able to keep your eligibility for coverage while your appeal is pending.
- The outcome of an appeal could change the eligibility of other members of your household.

To appeal your Marketplace eligibility results, visit **HealthCare.gov/marketplace-appeals/**. Or call the Marketplace Call Center at **1-800-318-2596**. TTY users should call **1-855-889-4325**. You can also mail an appeal request form or your own letter requesting an appeal to **Health Insurance Marketplace**, Dept. of Health and Human Services, 465 Industrial Blvd., London, KY 40750-0001. You can appeal eligibility for purchasing health coverage through the Marketplace, enrollment periods, tax credits, cost-sharing reductions, Medicaid, and CHIP, if you were denied these. If you qualify for tax credits or cost sharing reductions, you can appeal the amount we determined you're eligible for. Depending on your state, you may be able to appeal through the Marketplace or you may have to request an appeal with the state Medicaid or CHIP agency.

**PERSON 1 should sign this application.** If you're an authorized representative, you may sign here as long as PERSON 1 signed Appendix C.

| Signature | Date signed (mm/dd/yyyy) |
|---|---|
| | / / |

If you're signing this application outside of Open Enrollment (between November 1 and January 31), make sure you review Appendix D ("Questions about life changes").

## STEP 5: Mail completed application

Mail your signed application to:

**Health Insurance Marketplace**
**Dept. of Health and Human Services**
**465 Industrial Blvd.**
**London, KY 40750-0001**

If you want to register to vote, you can complete a voter registration form at **www.eac.gov**.

# Appendix C

Form Approved
OMB No. 0938-1191

## Assistance with completing this application

### For certified application counselors, navigators, agents, and brokers only

Complete this section if you're a certified application counselor, navigator, agent, or broker filling out this application for somebody else.

1. Application start date (mm/dd/yyyy)
   ☐☐/☐☐/☐☐☐☐

2. First name, Middle name, Last name, & Suffix

3. Organization name

4. ID number (if applicable)

5. Agents/Brokers only: NPN number

### You can choose an authorized representative.

You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative." If you ever need to change or remove your authorized representative, contact the Marketplace. If you're a legally appointed representative for someone on this application, submit proof with the application.

1. Name of authorized representative (First name, Middle name, Last name)

2. Address

3. Apartment or suite number

4. City

5. State

6. ZIP code

7. Phone number
   ☐☐☐ ☐☐☐-☐☐☐☐

8. Organization name

9. ID number (if applicable)

By signing, you allow this person to sign your application, get official information about this application, and act for you on all future matters related to this application.

**10. Signature of PERSON 1 listed on this application**

**11. Date signed** (mm/dd/yyyy)
☐☐/☐☐/☐☐☐☐

# Appendix D

Form Approved
OMB No. 0938-1191

## Questions about life changes

**(You must complete the rest of this application along with this page. Don't submit this page by itself.)**

If anyone on this application experienced certain life changes in the past 60 days, fill out the following questions. Certain life changes allow your coverage through the Marketplace to start right away. We also recommend you answer these questions if you're applying after the annual Open Enrollment Period ends and before the next annual Open Enrollment Period starts.

These questions are optional. If your life circumstances haven't changed, you can leave the answers blank. You can enroll in Medicaid and the Children's Health Insurance Program (CHIP) any time of the year, even if you didn't experience life changes. Members of federally recognized tribes and Alaska Native shareholders can enroll in coverage through the Marketplace any time of the year.

### Tell us about changes in your household.

**1. Did anyone lose qualifying health coverage in the last 60 days, or expect to lose qualifying health coverage in the next 60 days?**

Names | Date coverage ended or will end (mm/dd/yyyy) __/__/____

☐ Check here if coverage ended because not paying premiums.

**2. Did anyone get married in the last 60 days?**

Names | Date (mm/dd/yyyy) __/__/____

**3. Did anyone get released from incarceration (detention or jail) in the last 60 days?**

Names | Date (mm/dd/yyyy) __/__/____

**4. Did anyone gain eligible immigration status in the last 60 days?**

Names | Date (mm/dd/yyyy) __/__/____

**5. Was anyone adopted, placed for adoption, or placed for foster care in the last 60 days?**

Names | Date (mm/dd/yyyy) __/__/____

**6. Did anyone become a dependent due to a child support or other court order in the last 60 days?**

Names | Date (mm/dd/yyyy) __/__/____

**7. Did anyone change their primary place of living in the last 60 days?**

Names | Date of move (mm/dd/yyyy) __/__/____

What is the zip code of your previous address? ○ Fill in here if you moved from a foreign country or U.S. Territory

_____

**a. Did any of these people have qualifying health coverage at any time in the last 60 days?** ○ Yes ○ No

**If yes, enter their name(s) below:**

Names