A QUICK-START GUIDE TO THE

Health Insurance Marketplace Application

The Value of Health Insurance

Health coverage helps pay costs when you need care

No one plans to get sick or hurt, but most people need medical care at some point. Health coverage helps pay for these costs and protects you from very high expenses.

What is health insurance?

Health insurance is a contract between you and an insurance company. You buy a plan, and the company agrees to pay part of your medical costs when you get sick or hurt.

There are other important benefits of health insurance. Plans available in the Health Insurance Marketplace (and most other plans) provide free preventive care, like vaccines and check-ups. They also cover some costs for prescription drugs.

Health insurance helps you pay for care

Did you know the average cost of a 3-day hospital stay is $30,000? Or that fixing a broken leg can cost up to $7,500? Having health coverage can help protect you from high, unexpected costs like these.

Your insurance policy or summary of benefits and coverage will show what types of care, treatments, and services your plan covers, including how much the insurance company will pay for different treatments in different situations.

What you pay for health insurance

Here's a list of the documents that can be used to show your immigration status. See below for information about each document type. You can also see an example of what each document looks like by selecting the name of the document. On your application, select the document type from the drop-down list that corresponds with your most current documentation and status.

How much you pay for your premium and deductible is based on the type of coverage you have.

Just as important as the premium cost and deductible is how much you have to pay when you get services.

Examples include:

- What you pay out-of-pocket for services after you pay the deductible (coinsurance or copayments)
- How much in total you'll have to pay if you get sick (the out-of-pocket maximum)

The policy with the cheapest premium may not cover many services and treatments.

5 things to know about health insurance

1. Different health insurance policies can offer different benefits, and some can limit which doctors, hospitals, or other providers you can use.
2. You may have to pay a deductible each plan year before your insurance company starts to pay for care you get. For example, let's say your deductible is $200. You have a $1,250 emergency room visit. You pay the first $200 to cover the deductible, and then your insurance starts to pay its share.
3. You may have to pay coinsurance or a copayment when you get a medical service, like a doctor visit, hospital outpatient visit, or a prescription. Coinsurance is usually a percentage amount (for example, 20% of the total cost). A copayment is usually a fixed amount (for example, $10 or $20 for a prescription or doctor visit).
4. Health insurance plans contract with networks of hospitals, doctors, pharmacies, and health care providers. Depending on the type of policy you buy, your plan might only pay for your care when you get it from a provider in the plan's network, or you may have to pay a bigger share of the bill.
5. Starting in 2013, most people are required by law to have health insurance, or pay a fee with their income tax return.

Get more information about how insurance works at **HealthCare.gov**. You can also call the Health Insurance Marketplace Call Center at 1-800-318-2596. TTY users should call 1-855-889-4325.

For more information

If you have more than one current immigration document, select one that contains an alien number, if possible.

If you have temporary protected status (TPS), you may have an automatic extension of your status, even if your document is expired.

If you need help finding information on your document, check on the back of the document. Some older documents may not list all numbers. If you need help completing this section, or help with any other section of your Marketplace application, call the Marketplace Call Center at 1-800-318-2596. TTY users should call 1-855-889-4325.

Get Covered: A Guide to the Health Insurance Marketplace

- **The Marketplace helps uninsured people find health coverage.**
- **When you fill out the Marketplace application, we'll tell you if you qualify for:**
  - **Private insurance plans.** You might qualify for lower costs based on your household size and income. If you don't qualify for lower costs, you can still use the Marketplace to buy insurance. Plans cover essential health benefits, pre-existing conditions, and preventive care.
  - **Medicaid or the Children's Health Insurance Program (CHIP).** These programs cover millions of families with limited income, disabilities, and other circumstances. If it looks like you qualify, we'll share information with your state agency and they'll contact you.
- **No matter what state you live in, you can use the Marketplace.** Some states operate their own Marketplace. In other states, the Marketplace is run by the federal government.
- **If you can afford health insurance but choose not to buy it, you must have a health coverage exemption or pay a fee.** If you didn't have coverage in 2016, you'll have to pay a fee on your federal tax return of up to $695 per adult and $347.50 per child under 18. The fee is adjusted each year and could continue to go up.
- **You're considered covered** (and won't have to pay a fee) if you have Medicare Part A or Part C, Medicaid, CHIP, any job-based plan, an individual health plan, COBRA, retiree coverage, TRICARE, VA health coverage, or some other kinds of health coverage.
- **If you're eligible for job-based insurance, you can consider switching to a Marketplace plan.** But you won't qualify for lower costs based on your income unless the job-based insurance is unaffordable or doesn't meet minimum requirements. You also may lose any contribution your employer makes to your premiums.
- **Marketplace Open Enrollment for 2017 coverage is November 1, 2016–January 31, 2017.**
- **If you have certain life changes** (like moving to a new state, getting married, having a child, or losing health coverage), you may qualify for a Special Enrollment Period. This means you can enroll in or change your private plan outside Open Enrollment. You can apply for Medicaid and CHIP any time.
- **To apply or learn more,** visit **HealthCare.gov** or call the Marketplace Call Center at **1-800-318-2596**. TTY users should call 1-855-889-4325.

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 **https://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.

Health Insurance Marketplace

CMS Product No. 11749
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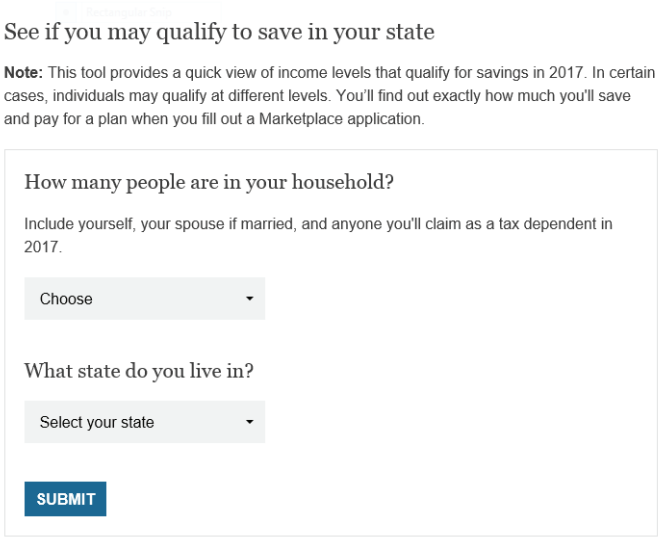
Do I Qualify to Save on Coverage?

To learn if you may qualify for lower costs on health coverage, visit HealthCare.gov/lower-costs for details. Enter the number of people in your household and the state you live in. Even if your state isn't expanding Medicaid and your income is below a certain amount, be sure to apply for Medicaid anyway. You may qualify under your state's current rules.



How can I help consumers learn about plans and pricing before applying?

You can see **plans and prices** on **HealthCare.gov** to help consumers preview plans and prices without first completing a Marketplace application. After answering some basic questions, you'll see all health and dental plans available in states where the federal government is operating the Marketplace.

Pricing information

Prices don't reflect the lower costs a consumer may qualify for based on household size and income when they apply. Many people who apply will qualify for reduced costs through tax credits that are automatically applied to monthly premiums. These credits will significantly lower the prices shown for a majority of those applying.

Note: Examples are offered for comparison purposes only. When an individual provides household and income information on the Marketplace application, the applicant's specific age, household makeup, and smoking status will be used to determine premium costs.

Get ready
to apply for or renew your
Health Insurance Marketplace coverage

You can apply for or renew your Marketplace coverage by visiting **HealthCare.gov** or by calling the Marketplace Call Center at 1-800-318-2596. TTY users should call 1-855-889-4325. To get started, you can visit HealthCare.gov to learn more about the Marketplace, sign up for text and email alerts, and plan your budget.

There are a few things you should gather to help make the application process quicker and easier. Gather this information before you go online or call to start your application, or before you meet with an in-person assister (like an agent, broker, or application counselor), if one of these people is helping you. To find an in-person assister in your area, visit **LocalHelp.HealthCare.gov**. If you don't take the time to gather these things now, you may need to log back in or call back several times before you can complete your application. You won't need all of these things if you're applying for coverage without financial help.

What do I need?	Why do I need this?	Have it ready!
Your information	Your Marketplace application will ask you for some basic information, including your name and date of birth.	☑

What do I need?	Why do I need this?	Have it ready!
Information about your household	Your Marketplace application will ask you about each person in your household, even those not applying for coverage. For the Marketplace, your household usually includes the tax filers and their tax dependents, but there are exceptions. Sometimes the Marketplace includes people you live with who aren't in your tax household. You should include yourself on your application. Here's a basic list of the other people you should generally include, if these apply to you: • Your spouse • Your children who live with you, even if they make enough money to file a tax return themselves • Anyone you include on your tax return as a dependent, even if they don't live with you • Anyone else under 21 who you take care of and who lives with you • Your unmarried partner, only if one or both of these apply: * They're your dependent for tax purposes * They're the parent of your child If you need more information, visit **HealthCare.gov/income-and-household-information/household-size**, or call the Marketplace Call Center at 1-800-318-2596.	
Home and/or mailing addresses for everyone applying for coverage	Where you live can affect what health coverage you're eligible for. You'll enter your home address to show if you're a resident of the state where you're seeking coverage (you'll select your state at the beginning of the application). You can't list a P.O. box as your home address. You'll be asked for your mailing address. Often, this will be the same as your home address. If it's not, pick a mailing address in the state you live in, if you can. You can enter a street address or a P.O. box. If anyone on your application has a different home and/or mailing address, you'll need to have it also.	
Information about everyone applying for coverage	Your Marketplace application will ask you to enter some basic information about everyone applying for coverage, including their relationship to you. Relationships include: spouse, domestic partner, parent, stepparent, parent's domestic partner, son/daughter, stepson/stepdaughter, child of domestic partner, brother/sister, uncle/aunt, and nephew/niece. Visit **HealthCare.gov/help/relationship-questions** for the complete list of relationships.	
Social Security Numbers (SSNs) for everyone on your application	Your Marketplace application will ask you to enter each person's 9-digit SSN, even those not applying for coverage. The Marketplace will verify the SSNs with Social Security, based on the consent you'll give at the start of your application. If you don't enter an SSN, you may need to provide more information at a later time. This information will only be used for eligibility for health coverage. For more information, visit **HealthCare.gov/help/do-i-need-to-enter-my-social-security-number-ssn**.	

What do I need?	Why do I need this?	Have it ready!
Information about the professional helping you apply (this only applies if you're getting help completing your application)	If a professional is helping you complete your application, you'll need to enter their information. These professionals include: navigators, certified application counselors, in-person assistance personnel, agents, or brokers. For more information on professional help, visit **HealthCare.gov/help/whos-helping-me-complete-my-application**.	
Immigration document information (this only applies to lawfully present immigrants)	If you or anyone else on your application is a lawfully present immigrant, you'll be asked to provide information from your immigration documents. For more on what information you'll need from your documents, visit **HealthCare.gov/help/immigration-document-types**.	
Information on how you'll file your taxes	If you file federal income taxes, the Marketplace needs to know: • If you're married, do you file separately or jointly? • Who do you claim as a tax dependent? For more information on how to answer these questions, visit **HealthCare.gov/help/what-do-i-need-to-enter-about-each-person**. If your household files more than one tax return, you'll need to file separate applications. For more information, visit **HealthCare.gov/help/what-if-my-household-files-more-than-one-tax-return**.	
Employer & income information for everyone in your household	Your Marketplace application may ask you about the income, expenses, and deductions of everyone in your household, even those not applying for coverage. The Marketplace accounts for income sources, including: • Wages and salaries, as reported on your W-2 form and pay stubs • Tips • Net income from any self-employment or business • Unemployment compensation • Social Security payments, including disability payments (but not Supplemental Security Income (SSI)) • Alimony • Retirement or pension income, including most IRA or 401k withdrawals • Investment income, like dividends or interest • Rental income • Other taxable income For more information on income or what income sources to include, visit **HealthCare.gov/income-and-household-information/income.**	

What do I need?	Why do I need this?	Have it ready!
Your best estimate of your household income	Your Marketplace application may ask you to estimate what your household's income will be in the year you'll be covered. If you're not sure, it's okay to make your best estimate. If your income changes, or is different than what you estimated, you'll need to report this later. For more information, visit **HealthCare.gov/reporting-changes/why-report-changes**. To help you make a ballpark estimate of your household income, visit **HealthCare.gov/income-and-household-information/how-to-report**.	☑
Health coverage information (this only applies if anyone in your household currently has a health plan)	Your Marketplace application will ask if anyone in your household is currently enrolled in health coverage, including Medicaid, the Children's Health Insurance Program (CHIP), Medicare, TRICARE, VA health care program, Peace Corps, or coverage through individual insurance or an employer. If anyone has coverage now, gather their policy numbers. You can find this information on their insurance card or documents they get from their plan.	☑
Employer information for each person in your household	Your Marketplace application will ask you to enter information about offers of health coverage you may have through your job or through a family member's job. It will also ask you to enter employer contact information for each person in your household who has a job.	☑
A completed "Employer Coverage Tool" (this is optional and only applies if anyone in your household has or is eligible for coverage through their employer)	You should fill out an "Employer Coverage Tool" for each member of your family who's eligible for a job-based plan, even if that person isn't enrolled in the job based plan or isn't applying for Marketplace coverage. You can get this information from your employer. This optional tool helps you gather information you may need for your application in one spot. To get a copy of this form, visit **HealthCare.gov/downloads/employer-coverage-tool.pdf**. Your employer can help you fill this out.	☑

Now that you've gathered all necessary information, visit **HealthCare.gov**, call the Marketplace Call Center at 1-800-318-2596, or meet with the professional helping you to apply for or renew your Marketplace coverage. TTY users should call 1-855-889-4325.

You have the right to get the information in this product in an alternate format. Visit https://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.

09/2016

Form Approved
OMB No. 0938-1213

Application for Health Coverage & Help Paying Costs

Apply faster online at HealthCare.gov

Use this application to see what coverage you qualify for

- Affordable private health insurance plans that offer comprehensive coverage to help you stay well.
- A new 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).

Who can use this application?

- Use this application to apply for anyone in your family.
- **Apply even if you or your child already has health coverage. You could be eligible for lower-cost or free coverage.**
- If you're single, you may be able to use a short form. Visit HealthCare.gov.
- Families that include immigrants can apply. You can apply for your child even if you aren't eligible for coverage. Applying won't affect your immigration status or chances of becoming a permanent resident or citizen.
- If someone is helping you fill out this application, you may need to complete Appendix C.

What you may need to apply

- Social Security Numbers (or document numbers for any eligible immigrants who need coverage).
- Employer and income information for everyone in your family (for example, from pay stubs, W-2 forms, or wage and tax statements).
- Policy numbers for any current health insurance.
- Information about any job-related health insurance available to your family.

Why do we ask for this information?

We ask about income and other information to let you know what coverage you qualify for and if you can get any help paying for it. **We'll keep all the information you provide private and secure, as required by law.** To view the Privacy Act Statement, visit HealthCare.gov or see instructions.

What happens next?

Send your complete, signed application to the address on page 7. **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 letter in the mail after your application is processed. If you don't hear from us, contact the Marketplace Call Center. Filling out this application doesn't mean you have to buy health coverage.

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**.

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?

STEP 2: Tell us about your family.

Who do you need to include on this application?
Complete the Step 2 pages for every person in your family and household, even if the person has health coverage already. The information in this application helps us make sure everyone gets the best coverage they can. The amount of help or type of program you qualify for is based on the number of people in your family and their incomes. If you don't include someone, even if they already have health coverage, your eligibility results could be affected.

For adults who need coverage:
*Include these people **even if they aren't applying for health coverage themselves:***

- Any spouse
- Any son or daughter under age 21 they live with, including stepchildren
- Any other person on the same federal income tax return (including any children over age 21 who are claimed on a parent's tax return). You don't need to file taxes to get health coverage.

For children under age 21 who need coverage:
*Include these people **even if they aren't applying for health coverage themselves:***

- Any parent (or stepparent) they live with
- Any sibling they live with
- Any son or daughter they live with, including stepchildren
- Any other person on the same federal income tax return. You don't need to file taxes to get health coverage.

Complete Step 2 for each person in your family.
Start with yourself, then add other adults and children. If you have more than 2 people in your family, you'll need to make a copy of the pages and attach them.

You don't need to provide immigration status or a Social Security Number (SSN) for family members who don't need health coverage. We'll keep all the information you provide private and secure, as required by law. We'll use personal information only to check if you're eligible for health coverage.

STEP 2: PERSON 1 (Start with yourself.)

Complete Step 2 for yourself, your spouse/partner and children who live with you, and/or anyone on your same federal income tax return if you file one. See page 1 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

1. First name	Middle name	Last name	Suffix

2. Relationship to PERSON 1?	3. Are you married?	4. Date of birth (mm/dd/yyyy)	5. Sex
SELF	◯ Yes ◯ No	/ /	◯ Male ◯ Female

6. **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.

7. **Do you plan to file a federal income tax return NEXT YEAR?** *You can still apply for coverage even if you don't file a federal income tax return.*

◯ **YES. If yes,** please answer questions a–c. ◯ **NO. If no,** skip to question c.

a. Will you file jointly with a spouse? ◯ Yes ◯ No

If yes, write name of spouse:

b. Will you claim any dependents on your tax return? ◯ Yes ◯ No

If yes, list name(s) of dependents:

c. Will you be claimed as a dependent on someone's tax return? ◯ Yes ◯ No

If yes, please list the name of the tax filer: How are you related to the tax filer?

8. Are you pregnant? ◯ Yes ◯ No a. **If yes,** how many babies are expected during this pregnancy? ☐

9. **Do you need health coverage?** *Even if you have coverage, there might be a program with better coverage or lower costs.*

◯ **YES. If yes**, answer all the questions below. ◯ **NO. If no,** SKIP to the income questions on page 3. Leave the rest of this page blank.

10. Do you have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.) or live in a medical facility or nursing home? ◯ Yes ◯ No

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

12. 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 13.

a. Alien number: b. Certificate number:

After you complete a and b, SKIP to question 14.

13. **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)**

a. Have you lived in the U.S. since 1996? ◯ Yes ◯ No

b. Are you, or your spouse or parent, a veteran or an active-duty member of the U.S. military? ◯ Yes ◯ No

14. Do you want help paying for medical bills from the last 3 months? ◯ Yes ◯ No

15. Do you live with at least one child under the age of 19, and are you the main person taking care of this child? *(Select "yes" if you or your spouse takes care of this child.)* ◯ Yes ◯ No

16. Tell us the names and relationships of any children under 19 that live with you in your household:

17. Are you a full-time student? ◯ Yes ◯ No 18. Were you in foster care at age 18 or older? ◯ Yes ◯ No

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

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

20. 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 2: PERSON 1 (Continue with yourself.)

Current job & income information

◯ **Employed:** If you're currently employed, tell us about your income. Start with question 21.

◯ **Not employed:** Skip to question 31.

◯ **Self-employed:** Skip to question 30.

Current job 1:

21. Employer name

a. Employer address

b. City | c. State | d. ZIP code | 22. Employer phone number

23. Wages/tips (before taxes) $

◯ Hourly ◯ Twice a month ◯ Weekly ◯ Monthly ◯ Every 2 weeks ◯ Yearly

24. Average hours worked each WEEK

Current job 2: (If you have additional jobs and need more space, attach another sheet of paper.)

25. Employer name

a. Employer address

b. City | c. State | d. ZIP code | 26. Employer phone number

27. Wages/tips (before taxes) $

◯ Hourly ◯ Twice a month ◯ Weekly ◯ Monthly ◯ Every 2 weeks ◯ Yearly

28. Average hours worked each WEEK

29. **In the past year, did you:** ◯ Change jobs ◯ Stop working ◯ Start working fewer hours ◯ None of these

30. **If self-employed, answer a and b:**

a. Type of work:

b. How much net income (profits once business expenses are paid) will you get from this self-employment this month? *See instructions.* $

31. **Other income you get this month:** Fill in all that apply, and give the amount and how often you get it. Fill in here if none. ◯

NOTE: You **don't** need to tell us about income from child support, veteran's payments, or Supplemental Security Income (SSI).

◯ Unemployment	$	How often?	◯ Alimony received	$	How often?
◯ Pension	$	How often?	◯ Net farming/fishing	$	How often?
◯ Social Security	$	How often?	◯ Net rental/royalty	$	How often?
◯ Retirement accounts	$	How often?	◯ Other income Type:	$	How often?

32. **Deductions:** Fill in all that apply, and give the amount and how often you pay it. If you pay for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.

NOTE: You shouldn't include child support that you pay, or a cost already considered in your answer to net self-employment (question 30b).

◯ Alimony paid	$	How often?	◯ Other deductions Type:	$	How often?
◯ Student loan interest	$	How often?			

33. **Complete this question if your income changes during the year**, like if you only work at a job for part of the year or receive a benefit for certain months. If you don't expect changes to your monthly income, skip to the next person.

Your total income **this year**	Your total income **next** year (if you think it will be different)
$	$

Thanks! This is all we need to know about you.

STEP 2: PERSON 2

Note: If this person doesn't need health coverage, just answer questions 1–11 on this page. Make a copy of pages 4–5 if there are more than 2 people in your household.

Complete this page for your spouse/partner and children who live with you, and/or anyone on your same federal income tax return if you file one. If you don't file a tax return, remember to still add family members who live with you. See page 1 for more information about who to include.

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

2. Relationship to PERSON 1? *See instructions.*

3. Is PERSON 2 married? ◯ Yes ◯ No

4. Date of birth (mm/dd/yyyy) ___/___/_____

5. Sex ◯ Male ◯ Female

6. Social Security Number (SSN) ___-___-____ **We need this if you want health coverage for PERSON 2, and PERSON 2 has an SSN.**

7. Does PERSON 2 live at the same address as PERSON 1? ◯ Yes ◯ No
If no, list address:

8. **Does PERSON 2 plan to file a federal income tax return NEXT YEAR?** *(You can still apply for coverage even if PERSON 2 doesn't file a federal income tax return.)*
◯ **YES. If yes,** please answer questions a–c. ◯ **NO. If no,** skip to question c.
a. Will PERSON 2 file jointly with a spouse? ◯ Yes ◯ No
If yes, write name of spouse:
b. Will PERSON 2 claim any dependents on his or her tax return? ◯ Yes ◯ No
If yes, list name(s) of dependents:
c. Will PERSON 2 be claimed as a dependent on someone's tax return? ◯ Yes ◯ No
If yes, please list the name of the tax filer: | How is PERSON 2 related to the tax filer?

9. Is PERSON 2 pregnant? ◯ Yes ◯ No a. **If yes,** how many babies are expected during this pregnancy? ☐

10. **Does PERSON 2 need health coverage?** *(Even if PERSON 2 has coverage, there might be a program with better coverage or lower costs.)*
◯ **YES. If yes**, answer all the questions below. ◯ **NO. If no,** SKIP to the income questions on page 5. Leave the rest of this page blank.

11. Does PERSON 2 have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.) or live in a medical facility or nursing home? ◯ Yes ◯ No

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

13. 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 14.
a. Alien number | b. Certificate number
After you complete a and b, SKIP to question 15.

14. **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 PERSON 2's spouse or parent, a veteran or an active-duty member of the U.S. military? ◯ Yes ◯ No

15. Does PERSON 2 want help paying for medical bills from the last 3 months? ◯ Yes ◯ No

16. Does PERSON 2 live with at least one child under the age of 19, and is PERSON 2 the main person taking care of this child? *(Select "yes" if PERSON 2 or their spouse takes care of this child.)* ◯ Yes ◯ No

17. Tell us the names and relationships of any children under 19 that live with PERSON 2 in their household: *(These can be the same children listed on page 2.)*

18. Was PERSON 2 in foster care at age 18 or older? ◯ Yes ◯ No

Please answer these questions if PERSON 2 is 22 or younger:

19. Did PERSON 2 have insurance through a job and lose it within the past 3 months? ◯ Yes ◯ No
a. **If yes**, end date: ___/___/_____ b. Reason the insurance ended:

20. Is PERSON 2 a full-time student? ◯ Yes ◯ No

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

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

22. 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 2: PERSON 2

Tell us about any income PERSON 2 gets.
Complete this page even if PERSON 2 doesn't need health coverage.

Current job & income information

◯ **Employed:** If **PERSON 2** is currently employed, tell us about his/her income. Start with question 23.

◯ **Not employed:** Skip to question 33.

◯ **Self-employed:** Skip to question 32.

Current job 1:

23. Employer name

a. Employer address

b. City | c. State | d. ZIP code | 24. Employer phone number

25. Wages/tips (before taxes) **$**
◯ Hourly ◯ Weekly ◯ Every 2 weeks
◯ Twice a month ◯ Monthly ◯ Yearly

26. Average hours worked each WEEK

Current job 2: (If PERSON 2 has more jobs, attach another sheet of paper.)

27. Employer name

a. Employer address

b. City | c. State | d. ZIP code | 28. Employer phone number

29. Wages/tips (before taxes) **$**
◯ Hourly ◯ Weekly ◯ Every 2 weeks
◯ Twice a month ◯ Monthly ◯ Yearly

30. Average hours worked each WEEK

31. **In the past year, did PERSON 2:** ◯ Change jobs ◯ Stop working ◯ Start working fewer hours ◯ None of these

32. **If PERSON 2 is self-employed, answer the following questions:**

a. Type of work:

b. How much net income (profits once business expenses are paid) will PERSON 2 get from this self-employment this month? *See instructions.* **$**

33. **Other income PERSON 2 gets this month:** Fill in all that apply, and give the amount and how often PERSON 2 gets it. Fill in here if none. ◯
NOTE: You **don't** need to tell us about PERSON 2's income from child support, veteran's payments, or Supplemental Security Income (SSI).

◯ Unemployment	$	How often?	◯ Alimony received	$	How often?
◯ Pension	$	How often?	◯ Net farming/fishing	$	How often?
◯ Social Security	$	How often?	◯ Net rental/royalty	$	How often?
◯ Retirement accounts	$	How often?	◯ Other income Type:	$	How often?

34. **Deductions:** Fill in all that apply, and give the amount and how often PERSON 2 gets it. If PERSON 2 pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.
NOTE: You shouldn't include child support that PERSON 2 pays, or a cost already considered in the answer to net self-employment (question 32b).

◯ Alimony paid	$	How often?	◯ Other deductions Type:	$	How often?
◯ Student loan interest	$	How often?			

35. **Complete only if PERSON 2's income changes during the year,** like if PERSON 2 only works at a job for part of the year or receives a benefit for certain months. If you don't expect changes to PERSON 2's monthly income, skip to the next person.

PERSON 2's total income **this year** **$**

PERSON 2's total income **next year** **$**

Thanks! This is all we need to know about PERSON 2.

STEP 3: American Indian or Alaska Native (AI/AN) family member(s)

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 to Step 4, plus complete Appendix B and include with application.

STEP 4: Your family's health coverage

1. **For every year that you got a premium tax credit, did your household file a tax return and reconcile any premium tax credit you used?**

◯ **YES, premium tax credits were reconciled. Fill in the circle only if ALL of these apply to you:**

- You used advance payments of premium tax credits (APTC) in one or more past years to help lower your costs for Marketplace coverage.
- The tax filer for your household filed a federal income tax return for each of these years.
- The tax filer(s) submitted IRS Form 8962 (**healthcare.gov/help/reconciling-your-tax-credit/**) with the tax return.

2. **Was anyone on this application found not eligible for Medicaid or the Children's Health Insurance Program (CHIP) in the past 90 days?** *(Select yes only if someone was found not eligible for this coverage by your state, not by the Marketplace.)* ◯ Yes ◯ No

Who?

Or, was anyone on this application found not eligible for Medicaid or CHIP due to their immigration status since October 1, 2013? ◯ Yes ◯ No

Who?

Did anyone on this application apply for coverage during the Marketplace open enrollment period? ◯ Yes ◯ No

Who?

3. **Is anyone listed on this application offered health coverage from a job?** *Check yes even if the coverage is from someone else's job, like a parent or spouse, even if they don't accept the coverage.*

◯ **YES.** Continue and then complete Appendix A. Is this a state employee benefit plan? ◯ Yes ◯ No

◯ **NO.**

4. **Is anyone enrolled in health coverage now?**

◯ **YES. If yes,** continue to question 6. ◯ **NO. If no,** SKIP to Step 5.

5. **Information about current health coverage.** *(Make a copy of this page if more than 2 people have health coverage now.)*
Write the type of coverage, like employer insurance, COBRA, Medicaid, CHIP, Medicare, TRICARE, VA health care program, Peace Corps, or other.
(Don't tell us about TRICARE if you have Direct Care or Line of Duty.)

PERSON 1:

Name of person enrolled in health coverage

Type of coverage:

◯ Employer insurance ◯ COBRA ◯ Medicaid ◯ CHIP ◯ Medicare ◯ TRICARE ◯ VA health care program ◯ Peace Corps ◯ Other

If it's employer insurance: *(You'll also need to complete Appendix A.)*

Name of health insurance company | Policy/ID number

If it's another kind of coverage: ◯ Fill in if this is Marketplace health coverage.

Name of health insurance company | Policy/ID number

Is this a limited-benefit plan, like a school accident policy? ◯ Yes ◯ No

PERSON 2:

Name of person enrolled in health coverage

Type of coverage:

◯ Employer insurance ◯ COBRA ◯ Medicaid ◯ CHIP ◯ Medicare ◯ TRICARE ◯ VA health care program ◯ Peace Corps ◯ Other

If it's employer insurance: *(You'll also need to complete Appendix A.)*

Name of health insurance company | Policy/ID number

If it's another kind of coverage: ◯ Fill in if this is Marketplace health coverage.

Name of health insurance company | Policy/ID number

Is this a limited-benefit plan, like a school accident policy? ◯ Yes ◯ No

STEP 5: Your agreement & signature

1. **Do you agree to allow the Marketplace to use income data, including information from tax returns, for the next 5 years?** ◯ Yes ◯ No

To make it easier to determine your eligibility for help paying for coverage in future years, you can agree to allow the Marketplace to use updated income data, including information from tax returns. The Marketplace will send a notice and let you make any changes. The Marketplace will check to make sure you're still eligible, and may have to ask you to prove that your income still qualifies. You can opt out at any time.

If no, automatically update my information for the next:

◯ 4 years ◯ 2 years ◯ Don't use my tax data to renew my eligibility for help paying for health coverage
◯ 3 years ◯ 1 year (selecting this option may impact your ability to get help paying for coverage at renewal.)

2. **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.

If anyone on this application is eligible for Medicaid:

- I'm giving to the Medicaid agency our rights to pursue and get any money from other health insurance, legal settlements, or other third parties. I'm also giving to the Medicaid agency rights to pursue and get medical support from a spouse or parent.
- Does any child on this application have a parent living outside of the home? ◯ Yes ◯ No
- If yes, I know I'll be asked to cooperate with the agency that collects medical support from an absent parent. If I think that cooperating to collect medical support will harm me or my children, I can tell Medicaid and I may not have to cooperate.
- 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 help paying for health coverage if you choose to apply. 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 6: 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.

NEED HELP WITH YOUR APPLICATION? Visit HealthCare.gov, or call us at **1-800-318-2596**. Para obtener una copia de este formulario en Español, llame **1-800-318-2596**. 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. TTY users should call **1-855-889-4325**.

Getting Help in a Language Other than English

If you, or someone you're helping, has questions about the Health Insurance Marketplace, you have the right to get help and information in your language at no cost. To talk to an interpreter, call **1-800-318-2596**.

Here's a listing of the available languages and the same message provided above in those languages:

Español (Spanish)

Usted tiene el derecho a recibir ayuda e información en su idioma sin costo alguno. Para comunicarse con un intérprete en español relacionado con el Mercado de seguros médicos, llame al 1-800-318-2596.

中文 (Chinese)

你有權利免費用您的語言獲得幫助和資訊。要用中文與傳譯員探討健康保險市場，請致電 1-800-318-2596。

tiếng Việt (Vietnamese)

Quý vị có quyền nhận sự giúp đỡ và thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên bằng tiếng Việt về Thị Trường Bảo Hiểm Sức Khỏe, xin gọi số 1-800-318-2596.

한국어 (Korean)

귀하는 귀하의 언어로 도움과 정보를 무료로 받을 수 있는 권리가 있습니다. 한국어로 건강 보험 시장(Health Insurance Marketplace)에 대하여 통역사에게 이야기하려면, 1-800-318-2596 번으로 전화하십시오.

العربية (Arabic)

لك الحق في الحصول على المساعدة والمعلومات في اللغة الخاصة بك مجانا. وللتحدث مع مترجم في اللغة العربية حول سوق التأمين الصحي، يرجى الاتصال على 1-800-318-2596.

Kreyòl (French Creole)

Ou gen tout dwa pou resevwa èd ak enfòmasyon nan lang ou pou gratis. Pou pale avèk yon entèpretè an Kreyòl konsènan Mache Asirans Medikal (Health Insurance Marketplace), rele 1-800-318-2596.

Tagalog (Tagalog)

Mayroon kang karapatan makakuha ng tulong at impormasyon sa iyong wika na walang gastos. Upang makipag-usap sa isang tagapagsalin sa Tagalog tungkol sa Health Insurance Marketplace, tumawag sa 1-800-318-2596.

Polski (Polish)

Każdy ma prawo uzyskać bezpłatnie pomoc i informacje we własnym języku. Aby porozmawiać z tłumaczem po polsku na temat Rynku Ubezpieczeń Zdrowotnych (Health, Insurance Marketplace), należy zadzwonić pod numer 1-800-318-2596.

Getting Help in a Language Other than English (Continued)

Русский (Russian)

Вы имеете право бесплатно получить помощь и информацию на родном языке. Чтобы поговорить с переводчиком на русском о платформе Health Insurance Marketplace (рынок медицинского страхования), позвоните по телефону 1-800-318-2596.

Français (French)

Vous avez le droit d'obtenir de l'aide et des renseignements dans votre langue sans aucun coût. Pour consulter un interprète en français quant au Marché d'assurance santé, composez le 1-800-318-2596.

Deutsch (German)

Sie haben das Recht, Hilfe und Informationen kostenlos in Ihrer eigenen Sprache in Anspruch zu nehmen. Um mit einem Dolmetscher für die deutsche Sprache über den „Health Insurance Marketplace“ zu sprechen, rufen Sie bitte diese Nummer an: 1-800-318-2596.

ગુજરાતી (Gujarati)

તમને વિના મૂલ્યે તમારી ભાષામાં મદદ અને માહિતી મેળવવાનો અધિકાર છે. આરોગ્ય વીમા વ્યાપારબજાર વિશે દુભાષિયા સાથે ગુજરાતીમાં વાતચીત કરવા, કૉલ કરો 1-800-318-2596

Português (Portuguese)

Você tem o direito de obter ajuda e informação em seu idioma e sem nenhum custo adicional. Para falar com um intérprete de [Português] sobre o Mercado de Seguros de Saúde, ligue para 1-800-318-2596.

Italiano (Italian)

Se voi, o una persona che state aiutando volete chiarimenti mercato delle assicurazioni mediche (Health Insurance Marketplace), avete il diritto di ottenere assistenza e informazioni nella vostra lingua a titolo gratuito. Per parlare con un interprete potete chiamare il numero 1-800-318-2596

日本語 (Japanese)

ご自身か、もしくはサポートされている誰かがHealth Insurance Marketplaceに問い合わせたい場合は、日本語サポートと情報提供を無料で得る資格を有しています。1-800-318-2596までご連絡いただき、通訳とお話しください。

Appendix A

Form Approved
OMB No. 0938-1191

Health Coverage from Jobs

You **DON'T** need to answer these questions unless someone in the household is eligible for health coverage from a job, even if they don't accept the coverage. Attach a copy of this page for each job that offers coverage.

Tell us about the job that offers coverage.

Make a copy of this page and take it to the employer who offers coverage to help you answer these questions.

Employee information

1. Employee name (First, Middle, Last)	2. Employee Social Security Number (SSN)
	___ - ___ - ____

Employer information

3. Employer/company name	
4. Employer Identification Number (EIN) ___ - _____	5. Employer phone number ___ ___ - ____

Now, enter the information of the person or department who manages employee benefits. We may contact this person if we need more information:

6. Person or department we can contact about employee health coverage		
7. Employer address (the Marketplace may send notices to this address)		
8. City	9. State	10. ZIP code
11. Phone number (if different from above) ___ ___ - ____	12. Email address	

13. Is the employee currently eligible for coverage offered by this employer, or will the employee become eligible in the next 3 months?

◯ **YES** (Continue)

◯ **NO** (**EMPLOYER:** STOP and return this form to the employee. **EMPLOYEE:** return to your application for Marketplace coverage.)

a. If the employee isn't eligible today, including as a result of a waiting or probationary period, when will the employee be eligible for coverage? (mm/dd/yyyy)

__ / __ / ____

b. Does the employer offer a health plan that covers this employee's spouse or dependent(s)?

◯ **YES. If yes,** which people? ◯ Spouse ◯ Dependent(s)

◯ **NO** (Go to question 14.)

List the names of anyone else in the employee's household who's eligible for coverage from this job.

Name

Name

Name

continued on the next page

Tell us about the health coverage offered by this employer.

14. Does the employer offer a health plan that meets the minimum value standard*?

◯ **YES** (Go to question 15.) ◯ **NO** (STOP and return this form to employee.)

15. How much would the employee have to pay for the lowest cost plan offered **to the employee only** that meets the minimum value standard*? Don't include family plans. **NOTE:** If the employer offers wellness programs, enter the premium that the employee would pay if the employee got the maximum discount for any tobacco cessation programs and didn't get any other discounts based on wellness programs.

a. Employee would pay this premium: **$**

NOTE: Enter the lowest amount the employee could pay for health coverage.

b. Employee would pay this amount: ◯ Weekly ◯ Every 2 weeks ◯ Twice a month ◯ Once a month ◯ Quarterly ◯ Yearly

(Go to next question.)

16. What changes will the employer make for the new plan year?

◯ Employer won't offer health coverage as of this date: (mm/dd/yyyy)

__/__/____

◯ The premium amount will change for the lowest-cost plan that meets the minimum value standard* and is available to the employee only. (Premium should only reflect discounts for tobacco cessation programs. See question 15.)

a. Employee would pay this premium: **$**

b. How often? ◯ Weekly ◯ Every 2 weeks ◯ Twice a month ◯ Once a month ◯ Quarterly ◯ Yearly

c. Date of change: (mm/dd/yyyy)

__/__/____

◯ I don't know if the employer will make changes.

◯ Employer won't make any of these changes.

*A health plan meets the minimum value standard if pays at least 60% of the total cost of medical services for a standard population and offers substantial coverage of hospital and doctor services. Most job-based plans meet the minimum value standard.

Appendix B

Form Approved
OMB No. 0938-1191

American Indian or Alaska Native Family Member (AI/AN)

Complete this appendix if you or a family member are American Indian or Alaska Native and are applying for coverage. Submit this with your "Application for Health Coverage & Help Paying Costs."

Tell us about your American Indian or Alaska Native family member(s).

American Indians and Alaska Natives can get services from the Indian Health Services, 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.

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

AI/AN PERSON 1:

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

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

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

3. Has this person ever gotten a service from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs? ◯ Yes ◯ No

If no, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? ◯ Yes ◯ No

4. Certain money received may not be counted for Medicaid or the Children's Health Insurance Program (CHIP). List any income (amount and how often) reported on your application that includes money from these sources:

- Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties
- Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations)
- Money from selling things that have cultural significance

$ | How often?

AI/AN PERSON 2:

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

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

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

3. Has this person ever gotten a service from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs? ◯ Yes ◯ No

If no, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? ◯ Yes ◯ No

4. Certain money received may not be counted for Medicaid or the Children's Health Insurance Program (CHIP). List any income (amount and how often) reported on your application that includes money from these sources:

- Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties
- Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations)
- Money from selling things that have cultural significance

$ | How often?

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

CMS Product No. 11708
October 2016

Instructions to Help You Complete the

Application for Health Coverage & Help Paying Costs

Starting November 1, you can apply for health coverage through the Health Insurance Marketplace. Coverage begins as soon as January 1. The Marketplace is designed to help you find health coverage that fits your budget and meets your needs.

Through a streamlined application process, you'll find out if you can get savings that you can use right away to help you pay your premium amount for private health coverage. You can also find out if you qualify for free or low-cost coverage through Medicaid or the Children's Health Insurance Program (CHIP).

For your convenience, there are different ways to apply to the Marketplace. The fastest way is to apply online at **HealthCare.gov**. If you apply online, you'll also get your eligibility results right away.

These instructions include additional help for some, but not all, of the items in the application.

Before you begin, it may help to have this information ready:

- Social Security Numbers (SSNs)
- Document numbers for eligible immigrants who want health coverage
- Birth dates
- Paystubs, W-2 forms, or other information about your family's income
- Policy/member numbers for any current health coverage
- Information about any health coverage from a job that's available to you or your family

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**.

Health Insurance Marketplace

There are 6 steps in this application.

Use blue or black ink to complete the application.

STEP 1: Tell us about yourself.

(Page 1)

An adult (18 or older) must complete the contact information. We need this information so we can follow up with you if we have questions about your application and so we can let you know what plans or programs you qualify for.

STEP 2: Tell us about your family.

(Page 1)

You need to provide information about everyone on your federal income tax return and all family members who live with you, even if they're not applying for health coverage. **Start with yourself.**

Your household size and income help determine what programs you qualify for. Read the information at the bottom of page 1 ("Who do you need to include on this application?") carefully to figure out which people to add in Step 2. The application has space for up to 2 people.

If you have more than 2 people in your household, make copies of pages 4–5 and complete them for each additional person.

Use this chart to help determine who should or shouldn't be included in this section.

	INCLUDE these people even if they aren't applying for health coverage themselves.	**DON'T INCLUDE these people if they want to apply for health insurance, they must fill out a separate application.**
For ADULTS who need coverage:	All people **who are on the same federal income tax return**, including: • Any spouse • Any sons or daughters, including stepchildren	Anyone **who isn't** on the same federal income tax return, including: • Any unrelated people who live in the same household • Any sons or daughters who aren't on the same tax return • Any parents or adult siblings, even if they live in the same household
For CHILDREN who need coverage:	All people **who are on the same federal income tax return**, including: • Any parents or stepparents • Any siblings	Anyone **who isn't** on the same federal income tax return, including: • Any unrelated people who live in the same household • Any parents who live in a different household

(Page 2)

PERSON 1 (Start with yourself)

Need health coverage?

Complete the whole page.

Don't need health coverage?

Complete items 1–9.

Item 7

You can still apply for coverage even if you don't plan to file a federal income tax return:

- If you're married and interested in getting a premium tax credit, you'll need to file your federal income tax return jointly with your spouse to get the tax credit.
- If you're claimed as a dependent on someone else's tax return, list the names of the tax filer(s).
- If you're claimed as a dependent, include how you're related to the tax filer.
  For example, if you're the child of the tax filer, list "child."

Item 10

If you have a physical, mental, or emotional health condition that limits activities like bathing, dressing, or daily chores, or if you live in a medical facility or nursing home, answering "yes" won't increase your health care costs. If you have a disability, you may qualify for free or low-cost coverage.

Item 11

If you're not a U.S. citizen but have eligible immigration status to get coverage through the Marketplace, check "yes" and provide your document type and document ID number(s) (see pages 7–9).
If you have more than one of these documents, list all of them.

Items 19–20

Ethnicity and race questions are optional. This information will help the U.S. Department of Health and Human Services (HHS) better understand and improve the health and health care for all Americans. Providing this information won't impact your eligibility for health coverage, your health plan options, or your costs in any way.

(Page 3)

PERSON 1: Current job & income information

We ask about your current income to see if you qualify for help paying for coverage and how much help you can get. Include how much you make in wages and tips before taxes are deducted. You don't have to include amounts taken out of your check by your employer for child care, health insurance, or retirement plans that are "not taxable" (sometimes called "pre-tax deductions").

If you're self-employed: Fill in the type of work you do and how much net income you'll get this month. Net income means the amount left over after you've taken out business expenses. The amount can be positive or negative. See the table of self-employment income deductions on page 9 of these instructions to find out what you can subtract from your gross income.

Item 32

Deductions: List any of the deductions you're able to claim from the front page of your 1040 federal income tax return.

STEP 2: Tell us about your family. (Continued)

(Page 4)

PERSON 2

Does PERSON 2 need health coverage?
Complete the whole page.

PERSON 2 doesn't need health coverage?
Complete items 1–10.

Item 2

Use these relationships to describe how PERSON 2 is related to you:

- Spouse
- Domestic partner
- Parent
- Stepparent
- Parent's domestic partner
- Son/daughter
- Stepson/stepdaughter
- Child of domestic partner
- Sibling
- Uncle/aunt
- Nephew/niece
- First cousin
- Grandparent
- Grandchild
- Other relative
- Other unrelated

Item 8

You can still apply for coverage even if PERSON 2 doesn't plan to file a federal income tax return:

- If PERSON 2 is married and interested in getting premium tax credits, PERSON 2 will need to file jointly with his or her spouse to get the tax credit.
- If PERSON 2 is claimed as a dependent on someone else's tax return, list the names of the tax filer(s).
- If PERSON 2 is claimed as a dependent, include how he or she is related to the tax filer(s).
  For example, if PERSON 2 is the child of the tax filer, list "child."

Item 11

If PERSON 2 has a physical, mental, or emotional health condition that limits activities like bathing, dressing, or daily chores, or if PERSON 2 lives in a medical facility or nursing home, answering "yes" won't increase their health care costs. If PERSON 2 has a disability, they may qualify for free or low-cost coverage.

Item 14

If PERSON 2 isn't a U.S. citizen but has eligible immigration status, check "yes" and provide their document type and document ID number(s) (see pages 7–9). If PERSON 2 has more than one of these documents, list all of them. Item 12 doesn't need to be completed if PERSON 2 isn't applying for health coverage.

Items 21–22

Ethnicity and race questions are optional. This information will help the U.S. Department of Health and Human Services (HHS) better understand and improve the health and health care for all Americans. Providing this information won't impact PERSON 2's eligibility for health coverage, your health plan options, or your costs in any way.

(Page 5)

PERSON 2: Current job & income information

Provide information about PERSON 2's current income to see if they're eligible for help paying for health coverage. Include how much PERSON 2 makes in wages and tips before taxes are deducted. You don't have to include amounts taken out of PERSON 2's check by their employer for child care, health insurance, or retirement plans that are "not taxable" (sometimes called "pre-tax deductions").

If PERSON 2 is self-employed: Fill in the type of work PERSON 2 does and how much net income they'll get this month. Net income means the amount left over after business expenses have been taken out. The amount can be positive or negative. See the table of self-employment income deductions on page 9 of these instructions to find out what can be subtracted from PERSON 2's gross income.

Item 34

Deductions: List any of the deductions PERSON 2 is able to claim from the front page of PERSON 2's 1040 federal income tax return.

STEP 3: American Indian or Alaska Native (AI/AN) family member(s)

(Page 6)

If anyone in your family is American Indian or Alaska Native, check "yes," complete Appendix B: American Indian or Alaska Native Family Member (AI/AN), and submit it with your application. There are special protections available for members of federally recognized tribes.

STEP 4: Your family's health coverage

(Page 6)

Item 1

Tell us if you filed a tax return and reconciled any premium tax credit used.

Item 2

If anyone was found not eligible for Medicaid or the Children's Health Insurance Program (CHIP), list their names here.

Item 4

If anyone in your family is offered health coverage from a job (whether it's their own job or another person's job), check "yes," even if they're offered coverage but aren't currently enrolled. If someone in your family is offered coverage, **you must** complete Appendix A: Health Coverage from Jobs, and submit it with your application. If no, skip to Step 5.

Item 5

If any of the people applying for health coverage are currently enrolled in a type of health coverage listed on page 6 of the application, check the type of coverage, write the person's name next to the coverage they have, and include other information as requested.

STEP 5: Read below & sign on the next page

(Page 7)

Read the statements on these pages, sign your name, and write today's date. By signing, you're agreeing that the information you provided is true and correct. If you or someone applying for health insurance on this application is incarcerated (detained or jailed), check yes and write their name in the space provided. If the person is pending disposition, check the box.

If an authorized representative helped you fill out this application, they can sign the form for you, but they'll need to complete Appendix C: Assistance with Completing this Application, and submit it with your application.

You (PERSON 1 on the application) must sign Appendix C to allow the authorized representative to sign this application, get official information about this application, and act for you on all future matters related to this application.

STEP 6: Mail completed application.

(Page 7)

Mail your original, signed application (and appendices, if applicable) to:

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

When you mail your application, be sure to use the correct amount of postage. The postage rate will depend on the weight of your application, which will be based on the number of pages you've included.

If you don't have all the information or you can't finish all the items, send in your application anyway. We'll follow up with you within 1–2 weeks.

Next Steps

You'll get information on how to enroll in a plan (if you're eligible) when you get your eligibility results.

Getting Help in a Language Other than English

Pages 8–9

If you or someone you're helping has a question about the Health Insurance Marketplace, you have the right to get help and information in your language at no cost.

Eligible immigration status list:

Use this list to answer questions about eligible immigration status. If you see your status below, check the box that says "yes."

- Lawful permanent resident (LPR/Green Card holder)
- Asylee
- Refugee
- Cuban/Haitian entrant
- Paroled into the U.S.
- Conditional entrant granted before 1980
- Battered spouse, child, or parent
- Victim of trafficking and his or her spouse, child, sibling, or parent
- Granted Withholding of Deportation or Withholding of Removal, under the immigration laws or under the Convention against Torture (CAT)
- Individual with non-immigrant status (including worker visas, student visas, and citizens of Micronesia, the Marshall Islands, and Palau)
- Temporary Protected Status (TPS)
- Deferred Enforced Departure (DED)
- Deferred Action Status (Deferred Action for Childhood Arrivals (DACA) isn't an eligible immigration status for applying for health coverage.)

- **Applicant for:**
  - Special Immigrant Juvenile Status
  - Adjustment to LPR Status with an approved visa petition
  - Victim of trafficking visa
  - Asylum who has either been granted employment authorization, OR is under 14 and has had an application for asylum pending for at least 180 days.
  - Withholding of Deportation or Withholding of Removal, under the immigration laws or under the Convention against Torture (CAT) who has either been granted employment authorization, OR is under 14 and has had an application for withholding of deportation or withholding of removal under the immigration laws or under the CAT pending for at least 180 days.

- **Certain individuals with employment authorization document:**
  - Registry applicants
  - Order of supervision
  - Applicant for Cancellation of Removal or Suspension of Deportation
  - Applicant for Legalization under IRCA
  - Applicant for Temporary Protected Status (TPS)
  - Legalization under the LIFE Act

- Lawful temporary resident
- Granted an administrative stay of removal by the Department of Homeland Security (DHS)
- Member of a federally recognized Indian tribe or American Indian born in Canada
- Resident of American Samoa

Immigration status and document types:

If you're an eligible non-citizen applying for health coverage, list your immigration document. See the list below for some common document types. If the document you have isn't listed, you can still write its name. If you're not sure, or you have an eligible status but no document, call the Marketplace Call Center at **1-800-318-2596** for help.

IF YOU HAVE:	LIST THESE FOR THE DOCUMENT ID:
Permanent Resident Card, "Green Card" (I-551)	• Alien registration number • Card number
Reentry Permit (I-327)	• Alien registration number
Refugee Travel Document (I-571)	• Alien registration number
Employment Authorization Card (I-766)	• Alien registration number • Card number • Expiration date • Category code
Machine Readable Immigrant Visa (with temporary I-551 language)	• Alien registration number • Passport number
Temporary I-551 Stamp (on passport or 1-94/1-94A)	• Alien registration number
Arrival/Departure Record (I-94/I-94A)	• I-94 number
Arrival/Departure Record in foreign passport (I-94)	• I-94 number • Passport number • Expiration date • Country of issuance
Foreign passport	• Passport number • Expiration date • Country of issuance
Certificate of Eligibility for Nonimmigrant Student Status (I-20)	• SEVIS ID
Certificate of Eligibility for Exchange Visitor Status (DS2019)	• SEVIS ID
Notice of Action (I-797)	• Alien registration number **or** an I-94 number
Other	• Alien registration number or an I-94 number • Description of the type or name of the document

For more eligible immigration documents or statuses, continue to the next page.

You can also list these documents or statuses:

- Document indicating a member of a federally recognized Indian tribe or American Indian born in Canada (**Note:** This is considered an eligible immigration status for Medicaid, but not for a Qualified Health Plan (QHP).)
- Office of Refugee Resettlement (ORR) eligibility letter (if under 18)
- Document indicating withholding of removal
- Administrative order staying removal issued by the Department of Homeland Security (DHS)
- Certification from U.S. Department of Health and Human Services (HHS) Office of Refugee Resettlement (ORR)
- Cuban/Haitian entrant
- Resident of American Samoa

For people who are self-employed:

If you have any of these expenses, you can subtract them from your gross income to get an amount for your net self-employment income:

- Car and truck expenses (for travel during the workday, not commuting)
- Employee wages and fringe benefits
- Interest (including mortgage interest paid to banks, etc.)
- Rent or lease of business property and utilities
- Advertising
- Repairs and maintenance
- Deductible self-employment taxes
- Contributions to a self-employed SEP, SIMPLE, or qualified retirement plan
- Property, liability, or business interruption insurance
- Depreciation
- Legal and professional services
- Commissions, taxes, licenses, and fees
- Contract labor
- Certain business travel and meals
- Cost of self-employed health insurance

Instructions to Help You Complete the Appendices

APPENDIX A

Health Coverage from Jobs

If anyone in your family has an offer of health coverage from a job, including through a parent or spouse, provide information on the offer of coverage, regardless of whether the person is currently enrolled.

Complete one page for each employer that offers health coverage. This appendix includes an Employer Coverage Tool to be given to the employer to answer questions about the coverage they offer.

APPENDIX B

American Indian or Alaska Native Family Member (AI/AN)

If you or a family member are American Indian or Alaska Native, complete Appendix B. You'll be asked about the person's tribe membership, income, and other information.

APPENDIX C

Assistance with Completing this Application

- **Certified application counselors, navigators, in-person assistance counselors, and other assisters:** These are professional individuals or organizations that are trained to help consumers looking for health coverage options through the Marketplace, including help with completing this application. Services are free to consumers. You can ask to see certification showing they're authorized to perform this work. They can help you complete this section. The ID number is the navigator's identification number. This is a unique alphanumeric ID (13 letters and numbers) given to each navigator.
- **Agents and brokers:** Agents and brokers can help you apply for help paying for coverage and enroll in a Qualified Health Plan (QHP) through the Marketplace. They can make specific recommendations about which plan you should enroll in. They're also licensed and regulated by states and typically get payments or commissions from health insurance companies when they enroll consumers. They can help you complete this section.

List both ID numbers for agents and brokers:

- **FFM User ID:** A unique ID that the agent or broker creates when registering with the Marketplace.
- **National Producer Number (NPN):** A unique number (up to 10 digits) that's assigned to each licensed agent or broker. An NPN can be easily located by going to the National Insurance Producer Registry's website at **www.nipr.com**.

You can choose an authorized representative:

Someone who you choose to act on your behalf with the Marketplace, like a family member or other trusted person. Some authorized representatives may have legal authority to act on your behalf.

APPENDIX D

Questions about life changes

A change in your life that can make you eligible for a Special Enrollment Period to enroll in health coverage. Examples of qualifying life events are moving to a new state, certain changes in your income, and changes in your family size (for example, if you marry, divorce, or have a baby).

Privacy Act Statement

Permission for information submitted

By submitting this application, you represent that you have permission from all of the people whose information is on the application to both submit their information to the Marketplace, and receive any communications about their eligibility and enrollment.

Privacy Act Statement – effective 10/1/2013

We are authorized to collect the information on this form and any supporting documentation, including social security numbers, under the Patient Protection and Affordable Care Act (Public Law No. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law No. 111-152), and the Social Security Act.

We need the information provided about you and the other individuals listed on this form to determine eligibility for: (1) enrollment in a qualified health plan through the Federal Health Insurance Marketplace, (2) insurance affordability programs (such as Medicaid, CHIP, advanced payment of the premium tax credits, and cost sharing reductions), and (3) certifications of exemption from the individual responsibility requirement. As part of that process, we will verify the information provided on the form, communicate with you or your authorized representative, and eventually provide the information to the health plan you select so that they can enroll any eligible individuals in a qualified health plan or insurance affordability program. We will also use the information provided as part of the ongoing operation of the Marketplace, including activities such as verifying continued eligibility for all programs, processing appeals, reporting on and managing the insurance affordability programs for eligible individuals, performing oversight and quality control activities, combatting fraud, and responding to any concerns about the security or confidentiality of the information.

While providing the requested information (including social security numbers) is voluntary, failing to provide it may delay or prevent your ability to obtain health coverage through the Marketplace, advanced payment of the premium tax credits, cost sharing reductions, or an exemption from the shared responsibility payment. If you don't have an exemption from the shared responsibility payment and you don't maintain qualifying health coverage for three months or longer during the year, you may be subject to a penalty. If you don't provide correct information on this form or knowingly and willfully provide false or fraudulent information, you may be subject to a penalty and other law enforcement action.

In order to verify and process applications, determine eligibility, and operate the Marketplace, we will need to share selected information that we receive outside of CMS, including to:

1. Other federal agencies, (such as the Internal Revenue Service, Social Security Administration and Department of Homeland Security), state agencies (such as Medicaid or CHIP) or local government agencies. We may use the information you provide in computer matching programs with any of these groups to make eligibility determinations, to verify continued eligibility for enrollment in a qualified health plan or Federal benefit programs, or to process appeals of eligibility determinations. Information provided by applicants won't be used for immigration enforcement purposes;
2. Other verification sources including consumer reporting agencies;
3. Employers identified on applications for eligibility determinations;
4. Applicants/enrollees, and authorized representatives of applicants/enrollees;
5. Agents, Brokers, and issuers of Qualified Health Plans, as applicable, who are certified by CMS who assist applicants/enrollees;
6. CMS contractors engaged to perform a function for the Marketplace; and
7. Anyone else as required by law or allowed under the Privacy Act System of Records Notice associated with this collection (CMS Health Insurance Exchanges System (HIX), CMS System No. 09-70-0560, as amended, 78 Federal Register, 8538, March 6, 2013, and 78 Federal Register, 32256, May 29, 2013).

Identity Verification

To protect your privacy, you will need to complete Identity Verification successfully before requesting higher account privileges. You are providing consent to Experian, an external identity verification provider, to access your personal information to conduct ID Verification on behalf of CMS. Below are a few items to keep in mind.

Ensure that you have entered your legal name, current home address, primary phone number, date of birth, and email address correctly. We will collect personal information only to verify your identity with Experian.

Identity Verification involves Experian using information from your consumer report profile to help confirm your identity. As a result, you may see an entry called a "soft inquiry" on your Experian consumer report. Soft inquiries are visible only to you, will never be presented to third parties, and do not affect your credit score. The soft inquiry will be titled "CMS Proofing Services" and will be removed from your Experian consumer report after 25 months.

You may need to have access to your personal and consumer report information, as the Experian application will pose questions to you, based on data in their files.

This statement provides the notice required by the Privacy Act of 1974 (5 U.S.C. § 552a(e)(3)). You can learn more about how we handle your information at: **https://www.healthcare.gov/how-we-use-your-data**.

Other Helpful Resources

Below are some other resources you may find useful as you help someone through the application process.

- Videos on plan compare (short and long version), cost sharing reduction, advance premium tax credit and more: **Marketplace.cms.gov/outreach-and-education/multimedia.html**.
- Marketplace consumer application job aid in other languages: **Marketplace.cms.gov/applications-and-forms/individuals-and-families-forms.html**.
- Examples of the notices that consumers get once they apply: **Marketplace.cms.gov/applications-and-forms/notices.html**.

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