09/2017

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 $98,400 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 _____

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**.

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 ◯ Twice a month ◯ Weekly ◯ Monthly ◯ Every 2 weeks ◯ 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 ◯ Twice a month ◯ Weekly ◯ Monthly ◯ Every 2 weeks ◯ 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? Date:

Or, was anyone on this application found not eligible for Medicaid or CHIP due to their immigration status in the last 4 years? ◯ 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 5. ◯ **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 ◯ 3 years ◯ 1 year ◯ Don't use my tax data to renew my eligibility for help paying for health coverage (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 December 15), 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)
	/ /

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

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