Health Insurance Marketplace

Application for Health Coverage & Help Paying Costs

Form Approved
OMB No. 0938-1191

THINGS TO KNOW

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 insurance 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 $94,000 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.

Apply faster online

Apply faster online at **HealthCare.gov**.

What you may need to apply

- Social Security numbers (or document numbers for any eligible immigrants who need insurance)
- Employer and income information for everyone in your family (for example, from paystubs, 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, go to **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. You'll get instructions on the next steps to complete your health coverage. If you don't hear from us, visit **HealthCare.gov** or call **1-800-318-2596**. Filling out this application doesn't mean you have to buy health coverage.

Get help with this application

- **Online:** **HealthCare.gov**
- **Phone:** Call our Help Center at **1-800-318-2596.**
- **In person:** There may be counselors in your area who can help. Visit **HealthCare.gov** or call **1-800-318-2596** for more information.
- **En Español:** Llame a nuestro centro de ayuda gratis al **1-800-318-2596.**

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 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

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

10. City | 11. State | 12. ZIP code | 13. County

14. Phone number ( ) –

15. Other phone number ( ) –

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

Email address:

17. What is your preferred spoken or written language (if not English)?

STEP 2 Tell us about your family.

Who do you need to include on this application?

Tell us about all the family members who live with you. If you file taxes, we need to know about everyone on your tax return. (You don't need to file taxes to get health coverage.)

DO Include:

- Yourself
- Your spouse
- Your children under 21 who live with you
- Your unmarried partner who needs health coverage
- Anyone you include on your tax return, even if they don't live with you
- Anyone else under 21 who you take care of and lives with you

You DON'T have to include:

- Your unmarried partner who doesn't need health coverage
- Your unmarried partner's children
- Your parents who live with you, but file their own tax return (if you're over 21)
- Other adult relatives who file their own tax return

The amount of assistance or type of program you qualify for depends on the number of people in your family and their incomes. This information helps us make sure everyone gets the best coverage they can.

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 you?
SELF

3. Date of birth (mm/dd/yyyy)
☐☐ / /

4. Sex
Male Female

5. Social Security number (SSN) - -

We need this if you want health coverage and have an SSN. Even if you don't want health coverage for yourself, providing your SSN can be helpful since it can speed up the application process. We use SSNs to check income and other information to see who's eligible for help with health coverage costs. For help getting an SSN, call 1-800-772-1213 or visit **socialsecurity.gov.** TTY users should call 1-800-325-0778.

6. **Do you plan to file a federal income tax return NEXT YEAR?**
(You can still apply for health insurance 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, 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?

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

8. **Do you need health coverage?**
(Even if you have insurance, 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.

9. 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

10. Are you a U.S. citizen or U.S. national? Yes No

11. **If you aren't a U.S. citizen or U.S. national,** do you have eligible immigration status? *(See instructions.)*
Yes. Fill in your document type and ID number below. No

a. Immigration document type:

b. Document ID number

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

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

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

13. Do you live with at least one child under the age of 19, and are you the main person taking care of this child? Yes No

14. Are you a full-time student? Yes No

15. Were you in foster care at age 18 or older? Yes No

16. **If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)**
Mexican Mexican American Chicano/a Puerto Rican Cuban Other

17. **Race (OPTIONAL—check all that apply.)**

White
Black or African American
American Indian or Alaska Native
Asian Indian
Chinese
Filipino
Japanese
Korean
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 18.

☐ **Not employed:** Skip to question 28.

☐ **Self-employed:** Skip to question 27.

CURRENT JOB 1:

18. Employer name

a. Employer address

b. City | c. State | d. ZIP code | 19. Employer phone number ( ) –

20. Wages/tips (before taxes) $ ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

21. Average hours worked each WEEK

CURRENT JOB 2: (If you have more jobs and need more space, attach another sheet of paper.)

22. Employer name

a. Employer address

b. City | c. State | d. ZIP code | 23. Employer phone number ( ) –

24. Wages/tips (before taxes) $ ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

25. Average hours worked each WEEK

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

27. **If self-employed, answer the following questions:**

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.)* $

28. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often you get it. Check here if none. ☐

NOTE: You don't need to tell us about child support, veteran's payment, 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?

29. **DEDUCTIONS:** Check all that apply, and give the amount and how often you get 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 a cost that you already considered in your answer to net self-employment (question 27b).

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

30. **YEARLY INCOME: Complete only if your income changes from month to month. 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.

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

If you have more than two people to include, make a copy of Step 2: Person 2 (pages 4 and 5) and complete.

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 you? *(See instructions.)*

3. Date of birth (mm/dd/yyyy) ☐☐ / /

4. Sex ☐ Male ☐ Female

5. Social Security number (SSN) - - **We need this if you want health coverage for PERSON 2 and PERSON 2 has an SSN.**

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

If no, list address:

7. **Does PERSON 2 plan to file a federal income tax return NEXT YEAR?**
(You can still apply for health insurance 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, 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?

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

9. **Does PERSON 2 need health coverage?**
(Even if PERSON 2 has insurance, 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.

10. 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

11. Is PERSON 2 a U.S. citizen or U.S. national? Yes No

12. **If PERSON 2 isn't a U.S. citizen or U.S. national,** do they have eligible immigration status? *(See instructions.)*

Yes. Fill in PERSON 2's document type and ID number below. No

a. Immigration document type: b. Document ID number

c. Has PERSON 2 lived in the U.S. since 1996? Yes No d. Is PERSON 2, or PERSON 2's spouse or parent, a veteran or an active-duty member of the U.S. military? Yes No

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

14. 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? Yes No

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

Please answer the following questions if PERSON 2 is 22 or younger:

16. 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:

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

18. **If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)**

Mexican Mexican American Chicano/a Puerto Rican Cuban Other

19. **Race (OPTIONAL—check all that apply.)**

White
Black or African American
American Indian or Alaska Native
Asian Indian
Chinese
Filipino
Japanese
Korean
Vietnamese
Other Asian
Native Hawaiian
Guamanian or Chamorro
Samoan
Other Pacific Islander
Other

Now, tell us about any income from PERSON 2 on the back.

STEP 2: PERSON 2

Current job & income information

☐ **Employed:** If PERSON 2 is currently employed, tell us about his or her income. Start with question 20.

☐ **Not employed:** Skip to question 30.

☐ **Self-employed:** Skip to question 29.

CURRENT JOB 1:

20. Employer name

a. Employer address

b. City | c. State | d. ZIP code | 21. Employer phone number ( ) –

22. Wages/tips (before taxes) $ ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

23. Average hours worked each WEEK

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

24. Employer name

a. Employer address

b. City | c. State | d. ZIP code | 25. Employer phone number ( ) –

26. Wages/tips (before taxes) $ ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

27. Average hours worked each WEEK

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

29. **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.)* $

30. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often PERSON 2 gets it. Check here if none. ☐

NOTE: You don't need to tell us about PERSON 2's child support, veteran's payment, or Supplemental Security Income (SSI).

☐ Unemployment $ How often? _____

☐ Pension $ How often? _____

☐ Social Security $ How often? _____

☐ Retirement accounts $ How often? _____

☐ Alimony received $ How often? _____

☐ Net farming/fishing $ How often? _____

☐ Net rental/royalty $ How often? _____

☐ Other income Type: $ How often? _____

31. **DEDUCTIONS:** Check 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 a cost that you already considered in your answer to net self-employment (question 29b).

☐ Alimony paid $ How often? _____

☐ Student loan interest $ How often? _____

☐ Other deductions Type: _____ $ How often? _____

32. **YEARLY INCOME: Complete only if PERSON 2's income changes from month to month. 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 (if you think it will be different) $

THANKS!

This is all we need to know about PERSON 2.

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 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,** skip to Step 4.

☐ **YES. If yes,** go to Appendix B.

STEP 4 Your family's health coverage

Answer these questions for anyone who needs health coverage.

1. **Is anyone enrolled in health coverage now from the following?**

☐ **YES. If yes**, check the type of coverage and write the person(s)' name(s) next to the coverage they have. ☐ **NO.**

☐ Medicaid _____

☐ CHIP _____

☐ Medicare _____

☐ TRICARE (Don't check if you have Direct Care or Line of Duty)

_____

☐ VA health care program _____

☐ Peace Corps _____

☐ Employer insurance _____

Name of health insurance: _____

Policy number: _____

Is this COBRA coverage? ☐ Yes ☐ No

Is this a retiree health plan? ☐ Yes ☐ No

☐ Other

Name of health insurance: _____

Policy number: _____

Is this a limited-benefit plan (like a school accident policy)?

☐ Yes ☐ No

2. **Is anyone listed on this application offered health coverage from a job?**

Check yes even if the coverage is from someone else's job, such as a parent or spouse.

☐ **YES. If yes,** you'll need to complete and include Appendix A. Is this a state employee benefit plan? ☐ Yes ☐ No

☐ **NO. If no, continue to Step 5.**

STEP 5 Read below & sign on the next page

- 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 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 the 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 my information on this form will be used only to determine eligibility for health coverage and will be kept private as required by law.
- Is anyone applying for health insurance on this application incarcerated (detained or jailed)? Yes No
  If yes, write the name of the person incrcerated here: _____
  Check here if this person is pending disposition of charges.

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.

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STEP 5 (Continued)

Renewal of coverage in future years

To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow the Marketplace to use income data, including information from tax returns. The Marketplace will send me a notice and let me make any changes, and I can opt out at any time.

Yes, renew my eligibility automatically for the next

☐ 5 years (the maximum number of years allowed), or for a shorter number of years:

☐ 4 years ☐ 3 years ☐ 2 years ☐ 1 year ☐ Don't use information from tax returns to renew my coverage.

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.

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, including how many days you have to request an appeal. Below is 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, log into your Marketplace account at **HealthCare.gov/marketplace/individual** or call **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 are 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.

Sign this application. The person who filled out Step 1 should sign this application. If you're an authorized representative, you may sign here as long as you've provided the information required in Appendix C.

Signature	Date (mm/dd/yyyy)
	☐☐ / ☐☐ / ☐☐☐☐

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 **usa.gov**.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1191. The time required to complete this information collection is estimated to average 45 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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**.

APPENDIX A

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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. Attach a copy of this page for each job that offers coverage.

Tell us about the job that offers coverage.

Take the Employer Coverage Tool on the next page to the employer who offers coverage to help you answer these questions. You only need to include this page when you send in your application, not the Employer Coverage Tool.

Employee information

1. Employee name (First, Middle, Last)	2. Employee Social Security number
	☐☐☐ - ☐☐ - ☐☐☐☐

Employer information

3. Employer name	4. Employer Identification Number (EIN)
	☐☐ - ☐☐☐☐☐☐☐
5. Employer address	6. Employer phone number
	( ) –
7. City	8. State / 9. ZIP code
	☐☐ / ☐☐☐☐☐
10. Who can we contact about employee health coverage at this job?	
11. Phone number (if different from above)	12. Email address
( ) –	

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

☐ **Yes** (Continue)

13a. **If you're in a waiting or probationary period, when can you enroll in coverage?** (mm/dd/yyyy)

☐☐ / ☐☐ / ☐☐☐☐

List the names of anyone else who is eligible for coverage from this job.

Name: _____ Name: _____ Name: _____

☐ **No** (Stop here and go to Step 5 in the application)

Tell us about the health plan offered by this employer.

14. Does the employer offer a health plan that meets the minimum value standard*? ☐ Yes ☐ No

15. For the lowest-cost plan that meets the minimum value standard* offered **only to the employee** (don't include family plans):
If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? $ ☐☐☐☐☐☐

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

16. What change will the employer make for the new plan year (if known)?

☐ Employer won't offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

☐☐☐☐☐☐

☐ ☐ ☐ ☐ ☐ ☐

☐☐ ☐☐ ☐☐☐☐

*An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986).

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EMPLOYER COVERAGE TOOL

Health Insurance Marketplace
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Use this tool to help answer questions in your Marketplace application, Appendix A. That part of the application asks about any employer health coverage that you're eligible for (even if it's from another person's job, like a parent or a spouse). The information in the numbered boxes below match the boxes in Appendix A. For example, you can use the answer to question 14 on this page to answer question 14 on Appendix A.
Write your name and Social Security number in boxes 1 and 2 and ask the employer to fill out the rest of the form. Complete one tool for each employer that offers health coverage that you're eligible for.

EMPLOYEE information

The **employee** needs to fill out this section.

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

EMPLOYER information

Ask the **employer** for this information.

3. Employer name	4. Employer Identification Number (EIN)
	__ - _____
5. Employer address (the Marketplace will send notices to this address)	6. Employer phone number
	( ) –
7. City	8. State / 9. ZIP code
	__ / _____
10. Who can we contact about employee health coverage at this job?	
11. Phone number (if different from above)	12. Email address
( ) –	

[redacted]

Tell us about the **health plan** offered by this **employer**.

Does the employer offer a health plan that covers an employee's spouse or dependent?

Yes. Which people? Spouse Dependent(s)

No

(Go to question 14)

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. For the lowest-cost plan that meets the minimum value standard* offered **only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? $

b. How often? Weekly Every 2 weeks Twice a month Once a month Quarterly Yearly (Go to next question)

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return this form to employee.

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

☐ Employer won't offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan that meets the minimum value standard* and is available to the employee only. (Premium should reflect the discount for wellness programs. See question 15.)

a. How much will the employee have to pay in premiums for that plan? $ ____

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

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

*An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986).

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**.

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. 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 following questions 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	AI/AN PERSON 2
1. Name (First name, Middle name, Last name)	First Middle Last	First Middle Last
2. Member of a federally recognized tribe?	Yes **If yes**, tribe name No	Yes **If yes**, tribe name No
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	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?	$ How often?

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APPENDIX C

Form Approved
OMB No. 0938-1191

Assistance with completing this application

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 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)
Shelley Burt, III

2. Address
5801 Osuna Rd NE

3. Apartment or suite number

4. City
Albuquerque

5. State
NM

6. ZIP code
87109

7. Phone number
(505) 837-9125

8. Organization name
Shelley Burt, III dba Health and Wealth Information Center

9. ID number (if applicable)
12876181

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. Your signature

11. Date (mm/dd/yyyy)
/ /

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
Shelley Burt, III

3. Organization name
Shelley Burt, III dba Health and Wealth Information Center

4. ID number (if applicable)
12876181

5. Agents/Brokers only: NPN number

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