Health Insurance Marketplace

Application for Health Coverage

Form Approved
OMB No. 0938-1191

THINGS TO KNOW

Who can use this application?

Anyone who needs health coverage can use this application.

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

Apply faster online

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

What happens next?

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

We'll follow up with you within 1–2 weeks to let you know how to join a health plan. 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 costs

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

- 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 $94,000 a year (for a family of 4). Visit **HealthCare.gov** or call **1-800-318-2596** to learn more.

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.**

10/2013

Use blue or black ink to complete this application.

STEP 1 Tell us about yourself.

(We'll 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)?

18. Do you need health coverage for yourself?

☐ Yes. **If yes**, answer all the questions below.

☐ No. **If no**, skip to Step 2 on page 2. (Leave the rest of this page blank)

19. Social Security number - -

We need Social Security numbers (SSNs) for anyone who wants coverage. We use SSNs to verify citizenship. For help getting an SSN, visit **socialsecurity.gov** or call 1-800-772-1213. TTY users should call 1-800-325-0778.

20. Sex ☐ Male ☐ Female

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

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

23. **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.

a. Immigration document type: _____

b. Document ID number

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

☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

25. **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 who else needs health coverage.

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 Tell us about anyone who needs health coverage.

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

STEP 2: PERSON 2

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

2. Relationship to you?

3. Social Security number ☐☐☐ - ☐☐ - ☐☐☐☐

4. Date of birth (mm/dd/yyyy) ☐☐ / ☐☐ / ☐☐☐☐

5. Sex ☐ Male ☐ Female

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

If no, list address: _____

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

8. **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.

a. Immigration document type: _____

b. Document ID number ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

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

☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

10. **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 3

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

2. Relationship to you?

3. Social Security number ☐☐☐ - ☐☐ - ☐☐☐☐

4. Date of birth (mm/dd/yyyy) ☐☐ / ☐☐ / ☐☐☐☐

5. Sex ☐ Male ☐ Female

6. Does PERSON 3 live at the same address as you? ☐ Yes ☐ No

If no, list address: _____

7. Is PERSON 3 a U.S. citizen or U.S. national? ☐ Yes ☐ No

8. **If PERSON 3 isn't a U.S. citizen or U.S. national,** do they have eligible immigration status? *(See instructions.)*

☐ Yes. Fill in PERSON 3's document type and ID number below.

a. Immigration document type: _____

b. Document ID number ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

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

☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

10. **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 _____

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

	AI/AN PERSON 1	AI/AN PERSON 2
2. Name (First name, Middle name, Last name)	First Middle Last	First Middle Last
3. Member of a federally recognized tribe?	☐ Yes **If yes**, tribe name _____ ☐ No	☐ Yes **If yes**, tribe name _____ ☐ No

STEP 4 Read & sign this application.

- I'm signing this application under penalty of perjury, which means I've provided true answers to all of 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 incarcerated here: _____
  ☐ Check here if this person is pending disposition of charges.
- I understand that my information will be used to check eligibility for health coverage. We'll check your answers using information in our electronic databases and databases from Social Security and the Department of Homeland Security. 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. 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, you must request an appeal within 90 days of the date of your eligibility notice. To request an appeal, log into your Marketplace account at **www.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 to purchase health coverage through the Marketplace and enrollment periods.

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)
	☐☐ / ☐☐ / ☐☐☐☐

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STEP 5 Mail completed application.

Mail your signed application to:

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

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

APPENDIX C

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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

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. 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

3. Organization name

4. ID number (if applicable) | 5. Agents/Brokers only: NPN number