Health Insurance Marketplace

Form Approved
OMB No. 0938-XXXX

Application for Exemption from the Shared Responsibility Payment for Individuals who are Unable to afford Coverage and are in Certain States with a State Based Marketplace

THINGS TO KNOW

Use this application to apply for an exemption from the shared responsibility payment

- Starting in 2014, every person needs to have health insurance or make a payment on their federal income tax return called the "shared responsibility payment."
- Some people are exempt from making this payment. This application includes one category of exemption, and you'll see other categories when you file your federal income tax return.
- You don't need to ask for an exemption if you're not going to file a federal income tax return because your income is below the filing threshold. If you aren't sure, you may want to ask for an exemption.

Who can use this application?

- **Use this application if your state has its own Marketplace. Visit HealthCare.gov, or call 1-800-318-2596 to see if your state has its own Marketplace. TTY users should call 1-855-889-4325.**
- **Use this application if you're unable to afford coverage. If you get this exemption, you may be able to buy catastrophic coverage.**
- Use this application to ask for an exemption for months in the future. If you want this exemption for a whole calendar year, you need to request it before the year starts. You can also claim an exemption on your federal income tax return if you're unable to afford coverage.
- You can use one application to ask for this exemption for more than one person in your tax household.

What you need to apply

- Social Security numbers (SSNs), if you have them.
- Employer and income information for everyone in your family (for example, from pay stubs, W-2 forms, or wage and tax statements).
- Information about any job-related health insurance available to your family.
- Proof of your yearly income for 2014. See page 6 for examples of documents you can send.

Why do we ask for this information?

We ask for Social Security numbers and other information to make sure your exemption is counted when you file your federal income tax return. **We'll keep all the information you give 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 5. We'll follow-up with you within 1–2 weeks and let you know if we need additional information. If you get this exemption, we'll give you an Exemption Certificate Number that you'll put on your federal income tax return. If you don't hear from us, visit HealthCare.gov, or call the Health Insurance Marketplace Help Center at **1-800-318-2596**. TTY users should call **1-855-889-4325**.

Get help with this application

- **Online:** HealthCare.gov.
- **Phone:** Call the Health Insurance Marketplace Call 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 tax household to be the contact person for your application.)

Are you in California, Colorado, the District of Columbia, Hawaii, Kentucky, Maryland, Massachusetts, Minnesota, Nevada, New York, Oregon, Rhode Island, Vermont, or Washington?

☐ **YES.** Fill out this application.

Are you in Connecticut?

☐ **YES.** Visit AccessHealthCT.com, or call 1-855-805-HEALTH (1-888-805-4325) to find out how to apply for this exemption.

Are you in another state?

☐ **YES.** Use the "Application for Exemption from the Shared Responsibility Payment for Individuals who are Unable to Afford Coverage and are in a State with a Federally Facilitated Marketplace."

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 everyone on your federal income tax return, even if they don't need this exemption. (If you get this exemption, you'll need to file taxes to use it.) If you get this exemption, we'll give you an Exemption Certificate Number with your approval letter. Keep this for your records. You'll need to put this number on your federal income tax return at the time you file taxes.

Complete Step 2 for each person in your family.

Start with yourself, then add other adults and children (whether or not they're requesting an exemption). If you have more than 2 people in your family, you'll need to make copies of page 2 and attach them. You don't need to provide immigration status or a Social Security number (SSN) for family members who don't need an exemption. 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 an exemption.

STEP 2: PERSON 1

Complete Step 2 for yourself and anyone on your same federal income tax return if you file one. See page 1 for more information about who to include. If you won't file a tax return because you'll have income below the filing threshold, you don't need to request this exemption.

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

2. Relationship to you

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

4. Sex ☐ Male ☐ Female

5. Social Security number (SSN) ☐☐☐ - ☐☐ - ☐☐☐☐

If you're requesting an exemption for yourself and you have an SSN, you must provide it. You aren't required to have an SSN to get this exemption. If you're not requesting an exemption for yourself, providing your SSN can be helpful because it can speed up the application process. We use SSNs to check income and other information to see who is eligible for an exemption, and to help make sure that if you get an exemption, it's applied correctly on your taxes. If you need help getting an SSN, visit **socialsecurity.gov**, or call **1-800-772-1213**. TTY users should call **1-800-325-0778**.

6. Tell us about the federal income tax return that you plan to file.

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. Do you need this exemption? ☐ **YES.** ☐ **NO.** **If no,** leave the rest of the page blank.

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

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

9. **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 _____

10. **YEARLY INCOME:** Include wages/tips (before taxes), net income from self-employment, unemployment benefits, pensions, Social Security (except Supplemental Security Income and old age, survivor's or disability payments that aren't taxable), retirement accounts, alimony received, net farming and fishing income, net rental and royalty income, and anything else that you would include on your taxes. You don't need to tell us about child support or veterans' payments.

Your total income **this year** $ ☐☐☐☐☐☐

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

11. If your employer withholds some of your wages and uses them to pay for health insurance, list the amount that is withheld each year.

$ ☐☐☐☐☐☐

12. Are you 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.

☐ **NO.**

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

STEP 2: PERSON 2

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

Complete Step 2 for yourself and anyone on your same federal income tax return if you file one. See page 1 for more information about who to include. If you won't file a tax return because you'll have income below the filing threshold, you don't need to request this exemption.

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

2. Relationship to you

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

4. Sex ☐ Male ☐ Female

5. Social Security number (SSN) ☐☐☐ - ☐☐ - ☐☐☐☐

If you're requesting an exemption for PERSON 2 and PERSON 2 has an SSN, you must provide it. PERSON 2 isn't required to have an SSN to get this exemption. If you're not requesting an exemption for PERSON 2, providing PERSON 2's Social Security number (SSN) can be helpful because it can speed up the application process. We use SSNs to check income and other information to see who is eligible for an exemption, and to help make sure that if you get an exemption, it's applied correctly on your taxes. If PERSON 2 needs need help getting an SSN, visit **socialsecurity.gov**, or call **1-800-772-1213**. TTY users should call **1-800-325-0778**.

6. Tell us about the federal income tax return that PERSON 2 plans to file NEXT YEAR.

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 are you related to the tax filer? _____

7. Does PERSON 2 need this exemption? ☐ **YES.** ☐ **NO.** **If no,** leave the rest of the page blank.

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

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

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

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

10. **YEARLY INCOME:** Include wages/tips (before taxes), net income from self-employment, unemployment benefits, pensions, Social Security (except Supplemental Security Income and old age, survivor's or disability payments that aren't taxable), retirement accounts, alimony received, net farming and fishing income, net rental and royalty income, and anything else that PERSON 2 would include on your taxes. You don't need to tell us about child support or veterans' payments.

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

PERSON 2's total income **next year** (if you think it will be different) $ ☐☐☐☐☐☐

11. If PERSON 2's employer withholds some of PERSON 2's wages and uses them to pay for health insurance, list the amount that is withheld each year.

$ ☐☐☐☐☐☐

12. Is PERSON 2 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.

☐ **NO.**

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

STEP 3 Lowest Cost Marketplace Plan

For anyone who is applying for this exemption who isn't offered health coverage through a job, including a spouse or parent's job, your ability to get this exemption is based on the cost of the lowest-cost bronze plan that is available through your state's Marketplace, after applying any tax credits you can get.

This information is only available through your state's Marketplace.

So, if anyone answered "No" to question 12 above—meaning that they aren't offered health coverage through a job—we need you to submit an application for health insurance to your state's Marketplace, complete the process, and send us 2 things:

1. A copy of the eligibility notice from your state's Marketplace that shows your maximum premium tax credit.
2. A copy of the screen from your Marketplace's plan comparison tool that shows the premium of the lowest-cost bronze plan available to everyone who is requesting this exemption. If there isn't a single bronze plan that covers everyone in your tax household who is requesting an exemption, send us the screens showing the lowest-cost bronze plans that add together to have the lowest cost for everyone.

If you need help locating this information, you can call your state's Marketplace. The phone numbers are listed below:

State	Phone number
California	1-800-300-1506
Colorado	1-855-PLANS-4-YOU (1-855-752-6749)
District of Columbia	1-855-532-5465
Hawaii	1-877-628-5076
Kentucky	1-855-4kynect (1-855-459-6238)
Maryland	1-855-642-8572
Massachusetts	1-877-623-6765
Minnesota	1-855-366-7873
Nevada	1-855-768-5465
New York	1-855-355-5777
Oregon	1-855-268-3767
Rhode Island	1-855-840-HSRI (1-855-840-4774)
Vermont	1-855-899-9600
Washington	1-855-WAFINDER (1-855-923-4633)

STEP 4 Read & sign this application.

- I'm signing this application under penalty of perjury, which means I've given 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 give false and or untrue information.
- 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**.

We need this information to check your eligibility for an exemption if you choose to apply. We'll check your answers using information in our electronic databases and databases from the Internal Revenue Service (IRS) 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 the results of my application are wrong?
If you don't agree with the results of your exemption application, you can ask for an appeal. Below is important information to consider when requesting an appeal:

- The Health Insurance Marketplace must receive your appeal request within 90 days of the date of the notice of the application results.
- 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.
- The outcome of an appeal could change the eligibility of other members of your household.

To appeal the results of your exemption application, 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 – Exemption Processing,** 465 Industrial Blvd., London, KY 40741.

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 have provided the required information listed in Appendix B.

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

STEP 5 Mail completed application and documents.

Mail your signed application and documents showing your yearly income (see examples on page 6) to:

Health Insurance Marketplace - Exemption Processing
465 Industrial Blvd.
London, KY 40741

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-XXXX. The time required to complete this information collection is estimated to average 16 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.

STEP 6 Proof of Yearly Income

In order to approve you for this exemption, we need proof of your yearly income for 2014. Examples of documents you can send include:

- Wages and tax statement (W-2)
- Pay stub
- Letter from employer
- Self-employment ledger
- Cost of living adjustment letter and other benefit verification notices
- Lease agreement
- Copy of a check paid to the household member
- Bank or investment fund statement
- Document or letter from Social Security Administration (SSA)
- Form SSA 1099 Social Security benefits statement
- Letter from government agency for unemployment benefits

These documents don't necessarily need to be dated for 2014. For example, you can provide recent pay stubs if you don't expect your income to change in 2014. If you expect your income to go up or down in 2014, you can provide other documents, like a document that states when contract work will end. If any of your income comes from freelance work, you can fill out a self-employment ledger that includes your expected income.

APPENDIX A: EXEMPTIONS

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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

15a. 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 they don't get a discount for wellness programs, including smoking cessation 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

15b. For the lowest-cost plan that meets the minimum value standard* offered **to the employee and family members requesting an exemption** (only include family plans for family members that do not already have an exemption): If the employer has wellness programs, provide the premium that the employee would pay if they don't get a discount for wellness programs, including smoking cessation 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 shouldn't reflect any 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).

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EMPLOYER COVERAGE TOOL: EXEMPTIONS

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
(☐☐☐) ☐☐☐ – ☐☐☐☐	

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**
- ☐ **Yes** (Go to question 13a.)
  - 13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____ (mm/dd/yyyy) (Go to next question)
- ☐ **No** (STOP and return this form to employee)

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)

15a. 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 they don't get a discount for wellness programs, including smoking cessation 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

15b. For the lowest-cost plan that meets the minimum value standard* offered **to the employee and family members requesting an exemption** (only include family plans for family members that do not already have an exemption): If the employer has wellness programs, provide the premium that the employee would pay if they don't get a discount for wellness programs, including smoking cessation 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

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 shouldn't reflect any 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

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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 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. 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