



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

DRAFT MOCKUP
OMB No. 0938-1190



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

- Every person needs to have health coverage or make a payment on his or her federal income tax return. This is called the “shared responsibility payment.”
- Some people are exempt from making this payment. This application includes one category of exemption. There are other applications for other categories of exemptions. You may apply for certain categories of exemptions when you file your federal income tax return.
- You don’t need to apply for an exemption if you’re not going to file a federal income tax return. If you’re not sure you’ll file a tax return, you may want to apply for an exemption anyway.



Who can use this application?

- **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 if your state has its own Marketplace. Visit [HealthCare.gov](https://www.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.**
- **You must list everyone in your tax household on a single application.**



When can you get this exemption?

Use this application to ask for an exemption for months in the future. **You can’t get this exemption for time in the past.** If you want this exemption for an entire calendar year, **you need to request it before January 1 of that year.** If you need this exemption for months in the past, you can apply for it when you file your tax return.



What you may 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 other tax forms).
- Information about any job-related health coverage available to your family.
- Proof of your expected yearly income for the year you need this exemption.
- The lowest cost bronze plan (LCBP) premium and any advanced premium tax credit from your state’s Marketplace website.



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](https://www.healthcare.gov) or see instructions.



Get help with this application

- **Online:** [HealthCare.gov](https://www.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](https://www.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**.



NEED HELP WITH YOUR APPLICATION? Visit [HealthCare.gov](https://www.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**.

SBM-AFFORDABILITY



Please print in capital letters using black or dark blue ink only. Fill in the circles (○) like this → ●.

STEP 1: Tell us about yourself.

(The person who files a federal income tax return in your household should be the contact person for this application. If you're applying for an exemption for a child, we need an adult who claims the child on his or her federal income tax return to fill out this information even if the adult doesn't need the exemption.)

Do you live in California, Colorado, the District of Columbia, Idaho, Maryland, Massachusetts, Minnesota, New York, Rhode Island, Vermont, or Washington?

- YES. Fill out this application.
- NO. Download the **FFM-Affordability exemption application** if you live in Alabama, Alaska, Arizona, Delaware, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Michigan, Mississippi, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Virginia, West Virginia, Wisconsin or Wyoming.

Give your legal name

1. First name	Middle name	Last name	Suffix
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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
-	-

Please give us a phone number so the Marketplace can contact you if we need more information to process your application. We won't use your phone number for any other purpose.

16. Do you want to get information by email from the Marketplace? Yes No

Email address:

17. What's your preferred spoken language? What's your preferred written language?

STEP 2: Tell us about your tax household.

Who do you need to include on this application?

You need to include every person in your household who is on the same federal income tax return.

Who not to include:

- A spouse who files taxes separately. Spouses who file separately need to fill out a separate application for themselves and for each person they claim on their tax return.
- Anyone who lives with you and isn't listed on your tax return. Each person who needs an exemption must be on an application with the person who lists him or her on a tax return.
- If you don't plan to file taxes, you don't need to apply for an exemption.
- You'll get an eligibility determination letter in the mail after your application is processed. If you get this exemption, we'll give you an Exemption Certificate Number (ECN) with your approval letter. Keep the letter for your records. You'll need to put this number on your federal income tax return at the time you file taxes.
- 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: Tell us about your tax household. (Start with yourself)

The person in line 1 must be the person who files a federal income tax return, even if the person doesn't need this exemption.

1. First name	Middle name	Last name	Suffix								
2. Relationship to you? SELF		3. Date of birth (mm/dd/yyyy) <table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table>									4. Sex <input type="radio"/> Male <input type="radio"/> Female

5. Social Security Number (SSN)

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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 help make sure that if you get an exemption, it's applied correctly on your taxes. If someone wants help getting an SSN, call **1-800-772-1213** or visit socialsecurity.gov. TTY users should call **1-800-325-0778**.

6. List the relationship to Person on line 1: names, DOB, SSN, and sex of anyone who would be on your federal tax return if you were going to file one. If you need this exemption so you can get an exemption from paying the tax penalty or catastrophic insurance, select YES for "Want Exemption?" Otherwise, select NO. Only list a spouse if you would file a **joint return**. Do not list a spouse if you would file married, filing separately. If you would file a single return, skip the table after checking the box below.

- a. Do you want this exemption for yourself? YES. NO.
- b. I would file a federal tax return as a single individual. (Skip table if you check this box and go to **Question 7**.)

Relationship to Person on line 1 (required) <i>(spouse or dependent)</i>	First Name (required)	Last Name (required)	Date of Birth MM/DD/YYYY (required)	Social Security Number ###-##-####	Sex	Want exemption? (required)																
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			<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table>											<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table>							<input type="radio"/> M <input type="radio"/> F	<input type="radio"/> YES. <input type="radio"/> NO.
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7. For what year and months do you or members of your tax household need this exemption?

Year	Months												
20__	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	January	February	March	April	May	June	July	August	September	October	November	December	

8. Yearly Income: We need to know about any income you or any other member of your tax household have made or expect to make from a job, self-employment, unemployment, retirement, pensions, rental property, fishing/farming, alimony, and Social Security (if taxable) during the year you want the exemption. **Submit a support document with your application for each type of income listed.**

The total **estimated income** for each member of your tax household **in the year** you want this exemption. List everyone on the application who makes any income, regardless of whether they want the exemption or not.

First Name	Last Name	Total Estimated Yearly Income
		\$
		\$
		\$
		\$
		\$
		\$



STEP 2: Tell us about any health coverage from a job.

9. Are you or any other individuals on this application offered health coverage from a job?

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

- YES. If yes,** list the first and last name of each person offered health coverage below and include an Appendix A that includes the cost of the premium for that employee and any covered family members.
- NO.**

First Name	Last Name

Optional:
(Fill in all that apply.)

- 10. **If Hispanic/Latino, ethnicity:** Mexican Mexican American Chicano/a Puerto Rican Cuban Other _____
- 11. **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 _____

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



STEP 3: Lowest cost Marketplace plan

Unless everyone listed on this application is offered health coverage from a job, you must submit this application with 2 pieces of information that are only available through your state's Marketplace. We **can't process** your application without this information.

If anyone listed on this application is not offered health coverage through a job, you need to submit an application for health coverage to your state's Marketplace, complete the process, and send us **two things**:

- 1. A copy of the eligibility notice from your application to your state's Marketplace. The notice needs to show the maximum premium tax credit for which you qualify. If you don't qualify for any premium tax credit, we still need the notice that shows you do not qualify.**
- 2. Information from your state Marketplace's web page that lists the health coverage plans available for you to buy. Print and mail us a screen shot that shows the monthly premium amount of the lowest-cost bronze level plan you can buy. Include the plan that's available to everyone who wants this exemption.**

Note: If a single Bronze plan doesn't cover everyone in your tax household who is requesting an exemption, send us the screenshots showing the lowest-cost Bronze plans that, added together, have the lowest cost for everyone.

If you need help locating this information, you can visit your state's Marketplace website or call them at the number listed below:

State	Website	Phone number
California	coveredca.com	1-800-300-1506
Colorado	connectforhealthco.com	1-855-PLANS-4-YOU (1-855-752-6749)
District of Columbia	dchealthlink.com	1-855-532-5465
Idaho	yourhealthidaho.org	1-855-YH-Idaho (1-855-944-3246)
Maryland	marylandhealthconnection.gov	1-855-642-8572
Massachusetts	mahealthconnector.org	1-877-MA-ENROLL (1-877-623-6765)
Minnesota	mnsure.org	1-855-366-7873
New York	nystateofhealth.ny.gov	1-855-355-5777
Rhode Island	healthsourceri.com	1-855-840-HSRI (1-855-840-4774)
Vermont	healthconnect.vermont.gov	1-855-899-9600
Washington	wahealthplanfinder.org	1-855-WAFINDER (1-855-923-4633)



STEP 4: Proof of yearly income

You MUST submit proof of each type of income you listed for each person on this application. We can't approve your exemption without proof of income. The table below lists possible documents for each type of income; you may submit other documents not on the list if they show the income amount you listed on your application.

If you expect your income to go up or down during the year you are requesting this exemption, 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.

Income Type	Documents
All income types	<ul style="list-style-type: none"> A copy of your most recent federal income tax return, Form 1040, if your income and/or deductions listed on this application are similar to your last tax return.
Job	<ul style="list-style-type: none"> One or more pay stubs that show the typical pay and hours you work at the job. The pay stubs should show the gross amount and any tips, commissions, bonuses, or overtime pay. Wages and tax statement (W-2) from the most recent year 1099-MISC (Non-employee compensation)
Net self-employment	<ul style="list-style-type: none"> Self-employment ledger Schedule C Form 1120S Other recent tax document showing self-employment Copy of a check paid for the self-employment services
Other income	Documents
Unemployment	<ul style="list-style-type: none"> Letter from government agency for unemployment benefits. If the document doesn't list the start and end dates, write your best guess on the document as to when the benefit will end on the document.
Retirement (taxable amounts ONLY)	<ul style="list-style-type: none"> 1099 or relevant tax document that lists any withdrawal amounts Documents showing taxable amount from account withdrawals
Pension	<ul style="list-style-type: none"> Pension letter 1099 or relevant tax document
Rental/royalties (net)	<ul style="list-style-type: none"> Lease agreement for land or property you own with lease amount/frequency Document showing royalty income 1099-MISC (royalty/rental income fields)
Alimony paid/received	<ul style="list-style-type: none"> Court order or legal document showing the monthly alimony amount and the start and end dates (if applicable)
Farming/fishing (net)	<ul style="list-style-type: none"> Schedule C Schedule F 1099-G
Social Security (taxable amounts ONLY)	<ul style="list-style-type: none"> Copy of most recent Form 1040 that shows the taxable amount in line 20b. Don't send copies of your benefit or COLA letter UNLESS the taxable amount is listed on it.



STEP 5: 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 [hhs.gov/ocr/office/file](https://www.hhs.gov/ocr/office/file).

Is anyone who is applying for an exemption 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.

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), Social Security Administration, 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 the results of my exemption 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 may have a relative, friend, legal counsel, or another spokesperson, including an Authorized Representative, help you make an appeal request or participate in your appeal. This is optional.
- The outcome of an appeal could change the eligibility of other members of your tax household.

To appeal your exemption application results, visit [HealthCare.gov/marketplace-appeals/](https://www.healthcare.gov/marketplace-appeals/). Or call the Marketplace Call Center at **1-800-318-2596**. TTY users should call **1-855-889-4325**.

PERSON 1 should sign this application. If you're an authorized representative, you may sign here as long as the Person signed Appendix C. The person who signs this application must be the person who files a federal income tax return and is an adult over the age of 18.

Signature

Date signed (mm/dd/yyyy)

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STEP 6: Mail completed application



Mail your signed application and documents showing your yearly income (see examples on page 5) to:

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



What happens next?

Send your complete, signed application with required documents to the address above. We'll follow up with you within 1–2 weeks. You may receive a call from the Marketplace if we need more information. You'll get an eligibility determination letter in the mail after we process your exemption application. If you qualify for this exemption, we'll give you an Exemption Certificate Number (ECN) that you'll put on your federal income tax return. If you don't hear from us, call the Health Insurance Marketplace Help Center at **1-800-318-2596**. TTY users should call **1-855-889-4325**.

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 0938-1190. 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 estimates 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](https://www.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 (Exemptions)



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 he or she doesn'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) <input type="text"/>	2. Employee Social Security Number <input type="text"/> - <input type="text"/> - <input type="text"/>
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EMPLOYER INFORMATION

3. Employer name

4. Is the employee currently eligible for coverage offered by this employer, or will the employee become eligible in the next 3 months?..... Yes No

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

If you answered No to question 4 and/or question 5 and you are applying for an SBM-affordability exemption, you do not need to fill out the remaining questions, but you need to apply for coverage on your state's Marketplace website and provide the LCBP and APTC amounts for each member of your tax household. See page 4 of the SBM-affordability exemption for more information.

If you answered No to question 4 and/or question 5 and you are applying for an FFM-affordability exemption, you do not need to fill out the remaining questions.

6. List the first and last names of anyone else in your tax household who is eligible for coverage from this job.

Name	Name	Name
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

Tell us about the lowest-cost health plan offered by this employer.

7. 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 or 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

8. For the lowest-cost plan that meets the minimum value standard* offered **to the employee and family members in your tax household**. If the employer has wellness programs, provide the premium that the employee would pay if he or she doesn'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

*A health plan meets the minimum value standard if it pays at least 60 percent 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 C



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) <input type="text"/>	
2. First name, Middle name, Last name, & Suffix <input type="text"/>	
3. Organization name <input type="text"/>	
4. ID number (if applicable) <input type="text"/>	5. Agents/Brokers only: NPN number <input type="text"/>

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) <input type="text"/>		
2. Address <input type="text"/>		3. Apartment or suite number <input type="text"/>
4. City <input type="text"/>	5. State <input type="text"/>	6. ZIP code <input type="text"/>
7. Phone number <input type="text"/> - <input type="text"/>		
8. Organization name <input type="text"/>		
9. ID number (if applicable) <input type="text"/>		

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 <input type="text"/>	11. Date signed (mm/dd/yyyy) <input type="text"/>
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