Health Insurance Marketplace

Form Approved
OMB No. 0938-1191
Expires: XX/XX/XXXX

Application for Health Coverage

Apply faster online at HealthCare.gov

Who can use this application?

Anyone who needs health coverage and isn't looking for help with costs can use this application.

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

What happens next?

Send your complete, signed application to the address on page 3. **If you don't have all the information we ask for, sign and submit your application anyway.**

We'll follow up with you within 1–2 weeks and you may get a call from the Marketplace if we need more information. You'll get an Eligibility Notice in the mail after we process your application.

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 tax credit that can immediately help lower your premiums for health coverage
- Free or low-cost coverage through Medicaid or the Children's Health Insurance Program (CHIP)

Certain income levels may qualify for free or low-cost programs. Visit **HealthCare.gov** or call the Marketplace Call Center to learn more.

Get help with this application

- **Online:** **HealthCare.gov**.
- **Phone:** Call the Marketplace Call Center at **1-800-318-2596**. TTY users can call **1-855-889-4325**.
- **In-person:** There may be counselors in your area who can help. Visit **HealthCare.gov**, or call the Marketplace Call Center at **1-800-318-2596** for more information.
- **En Español:** Llame a nuestro centro de ayuda gratis al **1-800-318-2596.**
- **Other languages:** If you need help in a language other than English, call **1-800-318-2596** and tell the customer service representative the language you need. We'll get you help at no cost to you.

You have the right to get Marketplace information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit **CMS.gov/about-cms/agency-Information/aboutwebsite/cmsnondiscriminationnotice**, or call the Marketplace Call Center at **1-800-318-2596** for more information. TTY users can call **1-855-889-4325**.

HealthCare.gov

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

Step 1: Tell us about yourself (PERSON 1).

(We need one adult in the household 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. Home address 2

4. City | 5. State | 6. ZIP code | 7. County

8. Mailing address (if different from home address) | 9. Home address 2

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

14. Daytime phone number ( ) -

15. Evening phone number ( ) -

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

Email address:

17. Preferred language: Written | Spoken

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 (SSN) - -

★ **We need an SSN if you want health coverage and have an SSN or can get one.** We use SSNs to check income and other information to see who's eligible for help paying for health coverage. For more information on getting an SSN, visit **socialsecurity.gov**, or call Social Security at 1-800-772-1213. TTY users can call 1-800-325-0778.

20. Sex
◯ Female ◯ Male

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

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

23. Are you a **naturalized** or **derived citizen**? *(This usually means you were born outside the U.S.)*
◯ **YES. If yes,** complete a and b. ◯ **NO. If no,** continue to question 24.

a. Alien number:

b. Certificate number:

After you complete a and b, skip to question 25.

24. **If you aren't a U.S. citizen or U.S. national,** do you have eligible immigration status? ◯ **YES.** Enter document type and ID number. See instructions.

Immigration document type | Status type (optional) | Write your name as it appears on your immigration document.

Alien or I-94 number | Card number or passport number

SEVIS ID or expiration date (optional) | Other (category code or country of issuance)

Optional: *(Fill in all that apply.)*

25. Are you of Hispanic, Latino/a, or Spanish origin? ◯ Yes ◯ No
If yes: ◯ Mexican ◯ Mexican American ◯ Chicano/a ◯ Puerto Rican ◯ Cuban ◯ Other _____

26. Race: ◯ 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.

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.)

PERSON 2

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

2. Relationship to PERSON 1

3. Social Security Number (SSN) ___ - ___ - ____

4. Date of birth (mm/dd/yyyy) __ / __ / ____

5. Sex ◯ Female ◯ Male

6. Does PERSON 2 live at the same address as PERSON 1? ◯ Yes ◯ No

If no, list address:

7. Is PERSON 2 **U.S. citizen** or **U.S. national**? ◯ Yes ◯ No

8. Is PERSON 2 a **naturalized** or **derived citizen**? *(This usually means they were born outside the U.S.)*

◯ **YES. If yes,** complete a and b. ◯ **NO. If no,** continue to question 9.

a. Alien number:

b. Certificate number:

After you complete a and b, skip to question 10.

9. **If PERSON 2 isn't a U.S. citizen or U.S. national,** do they have eligible immigration status? ◯ **YES.** Enter document type and ID number. *See instructions.*

Immigration document type | Status type (optional) | Write PERSON 2's name as it appears on their immigration document.

Alien or I-94 number | Card number or passport number

SEVIS ID or expiration date (optional) | Other (category code or country of issuance)

Is PERSON 2, or their spouse or parent, a veteran or an active-duty member of the U.S. military? ◯ Yes ◯ No

Optional: *(Fill in all that apply.)*

10. Are you of Hispanic, Latino/a, or Spanish origin? ◯ Yes ◯ No

If yes: ◯ Mexican ◯ Mexican American ◯ Chicano/a ◯ Puerto Rican ◯ Cuban ◯ Other _____

11. Race: ◯ 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 3: American Indians/Alaska Natives

American Indians and Alaska Natives can get services from the Indian Health Service, 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 these questions to make sure your household gets the most help possible.

1. **Are you or is anyone in your household American Indian or Alaska Native?**

◯ **NO. If no,** continue to Step 4. ◯ **YES. If yes,** continue. If you have more people to include, make a copy of this page and attach.

2. Name (First name, Middle name, Last name)

3. Member of a federally recognized tribe? ◯ Yes ◯ No

If yes, tribe name: | State tribe is located in:

Step 4: Your agreement & signature

Is anyone applying for health insurance on this application incarcerated (detained or jailed)? ◯ Yes ◯ No

If yes, tell us the person's name. The name of the incarcerated person is:

◯ Fill in here if this person is facing disposition of charges.

- 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 information.
- I know that I must tell the program I'll be enrolled in if the information I listed in this application changes. I know I can visit **HealthCare.gov** or call **1-800-318-2596** to report any changes. I know that a change in my information could affect my eligibility as well as eligibility for member(s) of my household.
- I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting **hhs.gov/ocr/office/file**.
- I know that information on this form will be used only to determine eligibility for health coverage, help paying for coverage (if requested), and for lawful purposes of the Marketplace and programs that help pay for coverage.

We need this information to check your eligibility for health coverage. We'll check your answers using information in our electronic databases and databases from the Internal Revenue Service (IRS), Social Security, the Department of Homeland Security, and/or a consumer reporting agency. If the information doesn't match, we may ask you to send us proof.

What should I do if I think my Eligibility Notice is wrong?

If you don't agree with what you qualify for, in many cases, you can ask for an appeal. Review your Eligibility Notice to find appeals instructions specific to each person in your household who applies for coverage, including how many days you have to request an appeal. Here's important information to consider when requesting an appeal:

- You can have someone request or participate in your appeal if you want to. That person can be a friend, relative, lawyer, or other individual. Or, you can request and participate in your appeal on your own.
- If you request an appeal, you may be able to keep your eligibility for coverage while your appeal is pending.
- The outcome of an appeal could change the eligibility of other members of your household.

To appeal your Marketplace eligibility results, visit **HealthCare.gov/marketplace-appeals**. Or, call the Marketplace Call Center at **1-800-318-2596**. TTY users can 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, Attn: Appeals, 465 Industrial Blvd., London, KY 40750-0001. You can appeal eligibility for purchasing health coverage through the Marketplace, enrollment periods, tax credits, cost-sharing reductions, Medicaid, and CHIP, if you were denied these. If you qualify for tax credits or cost-sharing reductions, you can appeal the amount we determined you're eligible for. Depending on your state, you may be able to appeal through the Marketplace or you may have to request an appeal with the state Medicaid or CHIP agency.

PERSON 1 should sign this application. If you're an authorized representative, you may sign here as long as PERSON 1 signed Appendix C.

Signature	**Date signed (mm/dd/yyyy)**
	/ /

If you're signing this application outside of Open Enrollment (between November 1 and January 15), make sure you review Appendix D ("Questions about life changes").

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 **eac.gov**.

Get help in a language other than English

If you, or someone you're helping, has questions about the Health Insurance Marketplace®, you have the right to get help and information in your language at no cost to you. To talk to an interpreter, call **1-800-318-2596**.

Here's a listing of the available languages and the same message provided above in those languages:

Español (Spanish)

Usted tiene el derecho a recibir ayuda e información en su idioma sin costo alguno. Para comunicarse con un intérprete en español relacionado con el Mercado de seguros médicos, llame al 1-800-318-2596.

中文 (Chinese)

你有權利免費用您的語言獲得幫助和資訊。要用中文與傳譯員探討健康保險市場，請致電 1-800-318-2596。

tiếng Việt (Vietnamese)

Quý vị có quyền nhận sự giúp đỡ và thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên bằng tiếng Việt về Thị Trường Bảo Hiểm Sức Khỏe, xin gọi số 1-800-318-2596.

한국어 (Korean)

귀하는 귀하의 언어로 도움과 정보를 무료로 받을 수 있는 권리가 있습니다. 한국어로 건강 보험 시장(Health Insurance Marketplace)에 대하여 통역사에게 이야기하려면, 1-800-318-2596 번으로 전화하십시오.

العربية (Arabic)

لك الحق في الحصول على المساعدة والمعلومات في اللغة الخاصة بك مجانا. وللتحدث مع مترجم في اللغة العربية حول سوق التأمين الصحي، يرجى الاتصال على 1-800-318-2596.

Kreyòl (French Creole)

Ou gen tout dwa pou resevwa èd ak enfòmasyon nan lang ou pou gratis. Pou pale avèk yon entèpretè an Kreyòl konsènan Mache Asirans Medikal (Health Insurance Marketplace), rele 1-800-318-2596.

Tagalog (Tagalog)

Mayroon kang karapatan makakuha ng tulong at impormasyon sa iyong wika na walang gastos. Upang makipag-usap sa isang tagapagsalin sa Tagalog tungkol sa Health Insurance Marketplace, tumawag sa 1-800-318-2596.

Get help in a language other than English (Continued)

Polski (Polish)

Każdy ma prawo uzyskać bezpłatnie pomoc i informacje we własnym języku. Aby porozmawiać z tłumaczem po polsku na temat Rynku Ubezpieczeń Zdrowotnych (Health, Insurance Marketplace), należy zadzwonić pod numer 1-800-318-2596.

Русский (Russian)

Вы имеете право бесплатно получить помощь и информацию на родном языке. Чтобы поговорить с переводчиком на русском о платформе Health Insurance Marketplace (рынок медицинского страхования), позвоните по телефону 1-800-318-2596.

Français (French)

Vous avez le droit d'obtenir de l'aide et des renseignements dans votre langue sans aucun coût. Pour consulter un interprète en français quant au Marché d'assurance santé, composez le 1-800-318-2596.

Deutsch (German)

Sie haben das Recht, Hilfe und Informationen kostenlos in Ihrer eigenen Sprache in Anspruch zu nehmen. Um mit einem Dolmetscher für die deutsche Sprache über den „Health Insurance Marketplace" zu sprechen, rufen Sie bitte diese Nummer an: 1-800-318-2596.

ગુજરાતી (Gujarati)

તમને વિના મૂલ્યે તમારી ભાષામાં મદદ અને માહિતી મેળવવાનો અધિકાર છે. આરોગ્ય વીમા વ્યાપારબજાર વિશે દુભાષિયા સાથે ગુજરાતીમાં વાતચીત કરવા, કૉલ કરો 1-800-318-2596

Português (Portuguese)

Você tem o direito de obter ajuda e informação em seu idioma e sem nenhum custo adicional. Para falar com um intérprete de [Português] sobre o Mercado de Seguros de Saúde, ligue para 1-800-318-2596.

Italiano (Italian)

Se voi, o una persona che state aiutando volete chiarimenti mercato delle assicurazioni mediche (Health Insurance Marketplace), avete il diritto di ottenere assistenza e informazioni nella vostra lingua a titolo gratuito. Per parlare con un interprete potete chiamare il numero 1-800-318-2596

日本語 (Japanese)

ご自身か、もしくはサポートされている誰かがHealth Insurance Marketplaceに問い合わせたい場合は、日本語サポートと情報提供を無料で得る資格を有しています。1-800-318-2596までご連絡いただき、通訳とお話しください。

Appendix C: Help with Completing this Application

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For certified application counselors, navigators, agents, and brokers only

Complete this section if you're a certified application counselor, navigator, agent, or broker filling out this application for somebody else.

1. Application start date (mm/dd/yyyy)

/ /

2. First name, Middle name, Last name, & Suffix

3. Organization name

4. ID number (if applicable)

5. Agents/Brokers only: NPN number

You can choose an authorized representative.

PERSON 1 only: You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative." If you ever need to change or remove your authorized representative, contact the Marketplace. If you're a legally appointed representative for someone on this application, submit proof with the application.

1. Name of authorized representative (First name, Middle name, Last name)

2. Address

3. Home address 2

4. City

5. State

6. ZIP code

7. Phone number

( ) -

8. Organization name

9. ID number (if applicable)

By signing, you allow this person to sign your application, get official information about this application, and act for you on all future matters related to this application.

10. Signature of PERSON 1 listed on this application

11. Date signed (mm/dd/yyyy)

/ /

Appendix D: Questions about life changes

Form Approved
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(You must complete the rest of this application along with this page. Don't submit this page by itself.)

If anyone on this application experienced certain life changes—like losing health coverage, getting married, or having a baby—in the past 60 days (OR expects to in the next 60 days), fill out this page and include it with your completed, signed application. Certain life changes allow your coverage through the Marketplace to start right away. We also recommend you answer these questions if you're applying outside Open Enrollment.

These questions are optional. If your life circumstances haven't changed, you can leave the answers blank. You can enroll in Medicaid and the Children's Health Insurance Program (CHIP) any time of the year, even if you didn't experience life changes. Members of federally recognized tribes and Alaska Native shareholders can enroll in coverage through the Marketplace any time of the year.

Tell us about changes in your household.

1. Did anyone lose qualifying health coverage (such as Medicaid, CHIP, coverage from a job, or COBRA) coverage in the last 60 days, or expect to lose qualifying health coverage in the next 60 days?

Name(s)	Date coverage ended or will end (mm/dd/yyyy)
	/ /

2. Did anyone get married in the last 60 days?

Name(s)	Date (mm/dd/yyyy)
	/ /

a. Did any of these people have qualifying health coverage at any time in the last 60 days? ◯ Yes ◯ No

If yes, enter their name(s) below:

Name(s)

3. Did anyone get released from incarceration (detention or jail) in the last 60 days?

Name(s)	Date (mm/dd/yyyy)
	/ /

4. Did anyone gain eligible immigration status in the last 60 days?

Name(s)	Date (mm/dd/yyyy)
	/ /

5. Did anyone gain a dependent (or become a dependent) due to an adoption, foster care placement, child support, or other court order in the last 60 days?

Name(s)	Date (mm/dd/yyyy)
	/ /

6. Did anyone move in the last 60 days?

Name(s)	Date of move (mm/dd/yyyy)
	/ /

a. What is the ZIP code of your previous address? ◯ Fill in here if you moved from a foreign country or U.S. territory

b. Did any of these people have qualifying health coverage at any time in the last 60 days? ◯ Yes ◯ No

If yes, enter their name(s) below:

Name(s)