

# Health Insurance Marketplace

## Application for Health Coverage



Form  
Approved OMB No.  
0938-1191  
Expires: 10/31/2025

➔ Apply faster online at [HealthCare.gov](https://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?

Make a copy to "keep, then 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, 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 may 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](https://HealthCare.gov) or call the Marketplace Call Center to learn more.



### Get help with this application

- Online: [HealthCare.gov](https://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 assisters in your area who can help. Visit [HealthCare.gov](https://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 your 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  
or call 1-800-318-2596. TTY users can call 1-855-889-4325.

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[HealthCare.gov](https://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 1 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<br>State   |  |                   | 11.  | 12. ZIP code   |  | 13. County        |  |
| 14. Daytime phone number<br>( ) ( ) ( ) ( ) ( ) ( ) - ( ) ( ) ( ) ( )   |  |                   |  | 15. Evening phone number<br>( ) ( ) ( ) ( ) ( ) ( ) - ( ) ( ) ( ) ( )            |  |                   |  |
| 16. Do you want to get information about this application by email? ..... <input type="radio"/> Yes <input type="radio"/> No  |  |                   |  |  |  |                   |  |
| Email address: _____  |  |                   |  |  |  |                   |  |
| 17. _____   |  |                   |  | Preferred language: Written _____ Spoken _____                                   |  |                   |  |
| 18. Do you need health coverage for yourself?<br><input type="radio"/> YES. If yes, answer all the questions below. <input type="radio"/> NO. If no, skip to Step 2 on page 2. (Leave the rest of this page blank.)   |  |                   |  |  |  |                   |  |
| 19. Social Security Number (SSN) _____ - _____ - _____<br>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 find out who's eligible for help paying for health coverage. For more information on getting an SSN, visit SSA.gov, or call Social Security at 1-800-772-1213. TTY users can call 1-800-325-0778. |  |                   |  |  |  |                   |  |
| 20. Sex<br><input type="radio"/> Female <input type="radio"/> Male  |  |                   | 21. Date of birth (mm/dd/yyyy)<br>____/____/____ |  |  |                   |  |
| 22. _____ citizen or U.S. national? ..... <input type="radio"/> Yes <input type="radio"/> No <b>Are you a U.S.</b>  |  |                   |  |  |  |                   |  |
| 23. Are you a naturalized or derived citizen? (This usually means you were born outside the U.S.)<br><input type="radio"/> YES. If yes, complete a and b. <input type="radio"/> NO. If no, continue to question 24.   |  |                   |  |  |  |                   |  |
| a. Alien number:<br>_____   |  |                   |  | b. Certificate number:<br>_____ 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? <input type="radio"/> YES. Enter document type and ID number. Go to instructions. Immigration document type _____ Status type (optional) _____ Write your name as it appears on your immigration document. _____  |  |                   |  |  |  |                   |  |
| Alien or I-94 number<br>_____   |  |                   |  | Card number or passport number<br>_____  |  |                   |  |
| SEVIS ID or expiration date (optional)<br>_____   |  |                   |  | Other (category code or country of issuance)<br>_____                            |  |                   |  |

continued on the next page



Optional: (Providing this information won't impact eligibility, plan options, or costs.)

Fill in all that apply.

If Hispanic/Latino, ethnicity:  Mexican  Chicano/  Puerto Rican  Cuban  Other

American  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

Choose one response.

Sex assigned at birth (may be found on your birth certificate)  
 Female  Male  Other  Don't know  Prefer not to answer

Current gender:  
 Female  Male  Transgender female  Transgender male  A different term:   Don't know  Prefer not to answer

Sexual orientation:  
 Bisexual  Lesbian or gay  Straight (not lesbian or gay)  A different term:   Don't know  Prefer not to answer

### Step 2: Tell us about anyone who needs health coverage.

(If you have more people to include, make a copy of pages 2-3 and attach.)

#### PERSON 2

|  |  |   |        |
|--|--|---|--------|
| 1. First name  | Middle name  | Last name   | Suffix |
| <input type="text"/>   |  |   |        |
| 2. Relationship to PERSON 1<br><input type="text"/>  |  |   |        |
| 3. Social Security Number (SSN)<br><input type="text"/>  | 4. Date of birth (mm/dd/yyyy)<br><input type="text"/>                | 5. Sex<br><input type="radio"/> Female <input type="radio"/> Male |        |
| 6. Does PERSON 2 live at the same address as PERSON 1? <input type="radio"/> Yes <input type="radio"/> No<br>If no, list address: <input type="text"/>   |  |   |        |
| 7. Is PERSON 2 U.S. citizen or U.S. national? <input type="radio"/> Yes <input type="radio"/> No   |  |   |        |
| 8. Is PERSON 2 a naturalized or derived citizen? (This usually means they were born outside the U.S.)<br>YES. If yes, complete a and b. NO. If no, continue to question 9.   |  |   |        |
| a. Alien number:<br><input type="text"/>   | b. Certificate number:<br><input type="text"/>                       |   |        |
| 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. Go to instructions. Immigration document type <input type="text"/> Status type (optional) <input type="text"/> <input type="radio"/> Write PERSON 2's name as it appears on their immigration document. <input type="text"/> |  |   |        |
| Alien or I-94 number<br><input type="text"/>   | Card number or passport number<br><input type="text"/>               |   |        |
| SEVIS ID or expiration date (optional)<br><input type="text"/>   | Other (category code or country of issuance)<br><input type="text"/> |   |        |
| Is PERSON 2, or their spouse or parent, a veteran or an active-duty member of the U.S. military? <input type="radio"/> Yes <input type="radio"/> No  |  |   |        |

continued on the next page



Optional: (Providing this information won't impact eligibility, plan options, or costs.)

Fill in all that apply.

If Hispanic/Latino, ethnicity:  Mexican  Chicano/  Puerto Rican  Cuban  Other

American  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

Choose one response.

Sex assigned at birth (may be found on PERSON 2's birth certificate)  
 Female  Male  Other  Don't know  Prefer not to answer

Current gender:  
 Female  Male  Transgender female  Transgender male  A different term:   Don't know  Prefer not to answer

Sexual orientation:  
 Bisexual  Lesbian or gay  Straight (not lesbian or gay)  A different term:   Don't know  Prefer not to answer

### Step 3: American Indian or Alaska Native (AI/AN) household member(s)

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, skip questions 2 and 3.  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:  

|  |  |
|--|--|
|  |  |
|--|--|

### Would you like information on registering to vote? (Optional)

Yes  No  Prefer not to answer  
 You can get information, registration deadlines, and find resources for your state at .



## 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 or untrue information.
- I know that I must tell the Health Insurance Marketplace within 30 days if anything changes (and is different than) what I wrote on this application. I can visit [HealthCare.gov](https://www.healthcare.gov) or call 1-800-318-2596 to report any changes. I understand 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/civil-rights/filing-a-complain](https://www.hhs.gov/civil-rights/filing-a-complain).
- 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?

You'll get an Eligibility Notice in the mail after we process your application. 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](https://www.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)   |
| <input style="width: 95%;" type="text"/> | <input style="width: 25%;" type="text"/> / <input style="width: 25%;" type="text"/> / <input style="width: 25%;" type="text"/> |

If you're signing this application outside of Open Enrollment (November 1-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

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 20 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.

# Appendix C: Help with Completing this Application



Form Approved  
OMB No. 0938-1191  
Expires: 10/31/2025

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)

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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5. Agents/Brokers only: NPN number

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|

You can choose an authorized representative.

You can give a trusted person permission to talk about this application with us, access 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

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|

7. Phone number

|   |  |  |  |   |  |  |  |   |  |  |  |  |
|---|--|--|--|---|--|--|--|---|--|--|--|--|
| ( |  |  |  | ) |  |  |  | - |  |  |  |  |
|---|--|--|--|---|--|--|--|---|--|--|--|--|

8. Organization name

9. ID number (if applicable)

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|

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

10. Signature of PERSON 1 listed on this application

11. Date signed (mm/dd/yyyy)

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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# Appendix D: Questions about life changes



(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 (November 1–January 15).

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 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) |
|         | <input type="text"/>                         |

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

|         |                      |
|---------|----------------------|
| Name(s) | Date (mm/dd/yyyy)    |
|         | <input type="text"/> |

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)    |
|         | <input type="text"/> |

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

|         |                      |
|---------|----------------------|
| Name(s) | Date (mm/dd/yyyy)    |
|         | <input type="text"/> |

5. Was anyone adopted, placed for adoption, or placed for foster care in the last 60 days?

|         |                      |
|---------|----------------------|
| Name(s) | Date (mm/dd/yyyy)    |
|         | <input type="text"/> |

6. Did anyone become a dependent due to a child support or other court order in the last 60 days?

|         |                      |
|---------|----------------------|
| Name(s) | Date (mm/dd/yyyy)    |
|         | <input type="text"/> |

7. Did anyone move in the last 60 days?

|         |                           |
|---------|---------------------------|
| Name(s) | Date of move (mm/dd/yyyy) |
|         | <input type="text"/>      |

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)