Application for Health Insurance

(and to find out if you can get help with costs)

THINGS TO KNOW

Use this application to see what insurance choices you qualify for

- Free or low-cost insurance from Medicaid or the Children's Health Insurance Program (CHIP)
- A new tax credit that can help pay your health insurance premiums
- Private health insurance plans

You may qualify for a free or low-cost program even if you earn as much as $92,000 a year (for a family of 4).

Who can use this application?

You can use this application to apply for anyone in your family, even if they already have insurance now.

You can still apply even if you don't file a federal income tax return.

Apply faster online

Apply faster online at www.placeholder.gov.

What you may need to apply

- Social Security numbers (or document numbers for any legal immigrants who need insurance)
- Birth dates
- Employer & income information for everyone in your family (for example, from paystubs or Forms W-2, Wage and Tax Statements)
- Policy numbers for any current health insurance
- Information about any job-related health insurance available to your family

Why do we ask for so much information?

We ask about income and other information to make sure you and your family get the most benefits possible. **We'll keep all the information you provide private, as required by law.**

What happens next?

Send your complete, signed application to the address on page 19. **If you don't have all the information we ask for, you should sign and submit your application anyway.**

We'll let you know what programs you might be eligible for within 1–2 weeks.

Get help with this application

- **Online:** www.placeholder.gov
- **Phone:** Call our Help Center at **1-800-XXX-XXXX**
- **In person:** Visit our website or call **1-800-XXX-XXXX** for a list of places near where you live
- **En Español:** Llame a nuestro centro de ayuda gratis al **1-800-XXX-XXXX**

NEED HELP WITH YOUR APPLICATION? Call us at 1-800-XXX-XXXX, or visit us at www.placeholder.gov.
Para obtener una copia de este formulario en Español, llame 1-800-XXX-XXXX.

STEP 1

Tell us about yourself.

(We will need to contact an adult member of the family.)

First Name, Middle Name, Last Name & Suffix

Home Address			Apartment Number
City	State	Zip Code	County
Mailing Address (if different from home address)			Apartment Number
City	State	Zip Code	County

☐ Check here if you don't have a home address. You still need to give a mailing address.

Phone Number	Other Phone Number
( ) –	( ) –

I would like to get information about this application by:

Email: ☐ Yes ☐ No Email Address: _____

Text: ☐ Yes ☐ No Cell Phone Number: ( ) – _____

Preferred Language Spoken (if not English)	Preferred Language Read (if not English)

STEP 2

Tell us about your family.

Your income and family size help us decide what programs you qualify for. With this information, we can make sure everyone gets the most coverage possible.

Here's who you need to include on this application:

- Your spouse, if married
- Your children who live with you
- Your partner who lives with you (but only if you have children together who need health insurance)
- Anyone you include on your federal income tax return

Anyone else who lives with you will need to file their own application if they want insurance. You don't need to file taxes to apply for health insurance.

Complete one page (front and back) for each person in your family. Start with yourself!
If you have more than 6 people in your family to include, you'll need to make a copy of the next 2 pages and complete.

Your information is private.

- We'll keep your information private as required by law.
- We'll use the information on this form only to see if you qualify for health insurance.

STEP 2: PERSON 1

Complete Step 2 for your spouse/partner and children who live with you and/or anyone on your same federal income tax return if you file one. See page 2 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you. **Start with yourself!**

First Name, Middle Name, Last Name & Suffix	Relationship to you? **SELF**

Social Security Number **OPTIONAL**	Date of birth (month/day/year)	Sex	Pregnant?
___ ___ ___ - ___ ___ - ___ ___ ___ ___		☐ Male ☐ Female	☐ Yes ☐ No **If yes,** how many babies are expected: ___

We need Social Security Numbers (SSNs) for everyone applying for health insurance who has one. An SSN is optional for people not applying for insurance, but providing an SSN can speed up the application process. We use SSNs to check income and other information to see who is eligible for help with insurance. If someone doesn't have an SSN, call 1-800-XXX-XXXX or visit **www.placeholder.gov**.

Does PERSON 1 plan to file a federal income tax return NEXT YEAR?

(You can still apply for health insurance even if you don't file a federal income tax return.)

☐ **YES. If yes,** please answer questions 1–3. ☐ **NO. If no,** skip to question 3.

1. Will PERSON 1 file jointly with a spouse/partner? ☐ Yes ☐ No
   If yes, name of spouse/partner: _____
2. Does PERSON 1 have any dependents? ☐ Yes ☐ No
   If yes, list name(s) of dependents: _____
3. Is PERSON 1 claimed as a dependent on someone else's tax return? ☐ Yes ☐ No
   If yes, please list the name of the tax filer: _____
   How is PERSON 1 related to the tax filer? _____

Is PERSON 1 applying for health insurance?

(Even if you have insurance, there might be a program with better coverage or lower costs.)

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

☐ **NO. If no,** SKIP to the income questions on page 4. Leave the rest of this page blank.

Social Security Number **REQUIRED** if you have one and if not listed above

___ ___ ___ - ___ ___ - ___ ___ ___ ___

Have a disability?	Needs help with activities of daily living through personal assistance services or a medical facility?
☐ Yes ☐ No	☐ Yes ☐ No

U.S. citizen or national?	
☐ Yes ☐ No	**If PERSON 1 isn't a U.S. citizen or national,** do they have eligible immigration status? ☐ Yes Go to page 20 for a list of eligible immigration statuses and add the information below. Document Type: _____ ID Number: _____ Has PERSON 1 lived in the U.S. since 1996? ☐ Yes ☐ No

Does PERSON 1 want help paying for medical bills from the last 3 months? ☐ Yes ☐ No

Does PERSON 1 live with at least one child under the age of 19 and are they the main person taking care of this child? ☐ Yes ☐ No

Please answer the following questions if PERSON 1 is 26 or younger:

Did PERSON 1 have insurance through a job and lose it within the past 3 months? ☐ Yes ☐ No

End date: _____ **Reason the insurance ended:** _____

Is PERSON 1 a full time student?	Was PERSON 1 ever in foster care?	Does PERSON 1 have a parent living outside the home?
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

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

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

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

NOW, tell us about any income from PERSON 1 on the back.

NEED HELP WITH YOUR APPLICATION? Call us at 1-800-XXX-XXXX, or visit us at www.placeholder.gov.
Para obtener una copia de este formulario en Español, llame 1-800-XXX-XXXX.

STEP 2: PERSON 1

CURRENT JOB and INCOME INFORMATION

☐ **Not employed**—Skip to "Other Income" lower on this page.

CURRENT JOB 1:

Employer name

Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Monthly ☐ Yearly
$

Average hours worked each WEEK

CURRENT JOB 2: (If you have more jobs and need more space, attach another sheet of paper.)

Employer name

Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Monthly ☐ Yearly
$

Average hours worked each WEEK

In the past 6 months, did PERSON 1:
☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

If self-employed, please answer the following questions:

Type of Work

How much net income (profits once expenses are paid) will PERSON 1 get from this self-employment this month? See instructions on page 20 to see what could be counted.
$

OTHER INCOME: Check all that apply, and give the amount and how often you get it.

NOTE: You don't need to tell us about child support, veteran's payment or Supplemental Security Income (SSI).

☐ None

☐ Unemployment **$** _____ How often? _____

☐ Pensions **$** _____ How often? _____

☐ Social Security **$** _____ How often? _____

☐ Retirement Accounts **$** _____ How often? _____

☐ Alimony **$** _____ How often? _____

☐ Capital Gains **$** _____ How often? _____

☐ Dividends/Interest **$** _____ How often? _____

☐ Net Farming/Fishing **$** _____ How often? _____

☐ Net Rental/Royalty **$** _____ How often? _____

☐ Other Income **$** _____ How often? _____
Type: _____

DEDUCTIONS: Check all that apply, and give the amount and how often you get it.

If PERSON 1 pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health insurance a little lower.

NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment.

☐ Alimony **$** _____ How often? _____

☐ Student loan interest **$** _____ How often? _____

☐ Other deductions **$** _____ How often? _____
Type: _____

YEARLY INCOME:

If the income you listed on this page is not steady from month to month, please tell us what you expect the yearly income to be. For example, some people expect their income to change because they only work some months of the year. If you don't expect changes to your monthly income, skip to Step 3.

PERSON 1's total income **this year**	PERSON 1's total income **next year**
$	**$**

THANKS! This is all we need to know about PERSON 1.

NEED HELP WITH YOUR APPLICATION? Call us at 1-800-XXX-XXXX, or visit us at www.placeholder.gov.
Para obtener una copia de este formulario en Español, llame 1-800-XXX-XXXX.

STEP 2: PERSON 2

Complete Step 2 for your spouse/partner and children who live with you and/or anyone on your same federal income tax return if you file one. See page 2 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

First Name, Middle Name, Last Name & Suffix	Relationship to you?

Social Security Number **OPTIONAL**	Date of birth (month/day/year)	Sex	Pregnant?
___ ___ ___ - ___ ___ - ___ ___ ___ ___		☐ Male ☐ Female	☐ Yes ☐ No **If yes,** how many babies are expected: ____

Does this PERSON 2 live at the same address as you? ☐ Yes ☐ No **If no,** list address: _____

Does PERSON 2 plan to file a federal income tax return NEXT YEAR?

(You can still apply for health insurance even if you don't file a federal income tax return.)

☐ **YES. If yes,** please answer questions 1–3. ☐ **NO. If no,** skip to question 3.

1. Will PERSON 2 file jointly with a spouse/partner? ☐ Yes ☐ No
   If yes, name of spouse/partner: _____
2. Does PERSON 2 have any dependents? ☐ Yes ☐ No
   If yes, list name(s) of dependents: _____
3. Is PERSON 2 claimed as a dependent on someone else's tax return? ☐ Yes ☐ No
   If yes, please list the name of the tax filer: _____
   How is PERSON 2 related to the tax filer? _____

Is PERSON 2 applying for health insurance?

(Even if you have insurance, there might be a program with better coverage or lower costs.)

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

☐ **NO. If no,** SKIP to the income questions on page 6. Leave the rest of this page blank.

Social Security Number **REQUIRED** if you have one and if not listed above

___ ___ ___ - ___ ___ - ___ ___ ___ ___

Have a disability?	Needs help with activities of daily living through personal assistance services or a medical facility?
☐ Yes ☐ No	☐ Yes ☐ No

U.S. citizen or national?	
☐ Yes ☐ No	**If PERSON 2 isn't a U.S. citizen or national,** do they have eligible immigration status? ☐ Yes Go to page 20 for a list of eligible immigration statuses and add the information below. Document Type: _____ ID Number: _____ Has PERSON 2 lived in the U.S. since 1996? ☐ Yes ☐ No

Does PERSON 2 want help paying for medical bills from the last 3 months? ☐ Yes ☐ No

Does PERSON 2 live with at least one child under the age of 19 and are they the main person taking care of this child? ☐ Yes ☐ No

Please answer the following questions if PERSON 2 is 26 or younger:

Did PERSON 2 have insurance through a job and lose it within the past 3 months? ☐ Yes ☐ No

End date: _____ **Reason the insurance ended:** _____

Is PERSON 2 a full time student?	Was PERSON 2 ever in foster care?	Does PERSON 2 have a parent living outside the home?
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

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

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

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

NOW, tell us about any income from PERSON 2 on the back.

STEP 2: PERSON 2

CURRENT JOB and INCOME INFORMATION

☐ **Not employed**—Skip to "Other Income" lower on this page.

CURRENT JOB 1:

Employer name

Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Monthly ☐ Yearly
$

Average hours worked each WEEK

CURRENT JOB 2: (If you have more jobs and need more space, attach another sheet of paper.)

Employer name

Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Monthly ☐ Yearly
$

Average hours worked each WEEK

In the past 6 months, did PERSON 2:
☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

If self-employed, please answer the following questions:

Type of Work

How much net income (profits once expenses are paid) will PERSON 2 get from this self-employment this month? See instructions on page 20 to see what could be counted.
$

OTHER INCOME: Check all that apply, and give the amount and how often you get it.

NOTE: You don't need to tell us about child support, veteran's payment or Supplemental Security Income (SSI).

☐ None

☐ Unemployment **$** _____ How often? _____

☐ Pensions **$** _____ How often? _____

☐ Social Security **$** _____ How often? _____

☐ Retirement Accounts **$** _____ How often? _____

☐ Alimony **$** _____ How often? _____

☐ Capital Gains **$** _____ How often? _____

☐ Dividends/Interest **$** _____ How often? _____

☐ Net Farming/Fishing **$** _____ How often? _____

☐ Net Rental/Royalty **$** _____ How often? _____

☐ Other Income **$** _____ How often? _____
Type: _____

DEDUCTIONS: Check all that apply, and give the amount and how often you get it.

If PERSON 2 pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health insurance a little lower.

NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment.

☐ Alimony **$** _____ How often? _____

☐ Student loan interest **$** _____ How often? _____

☐ Other deductions **$** _____ How often? _____
Type: _____

YEARLY INCOME:

If the income you listed on this page is not steady from month to month, please tell us what you expect the yearly income to be. For example, some people expect their income to change because they only work some months of the year. If you don't expect changes to your monthly income, skip to Step 3.

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

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

NEED HELP WITH YOUR APPLICATION? Call us at 1-800-XXX-XXXX, or visit us at www.placeholder.gov.
Para obtener una copia de este formulario en Español, llame 1-800-XXX-XXXX.

STEP 2: PERSON 3

Complete Step 2 for your spouse/partner and children who live with you and/or anyone on your same federal income tax return if you file one. See page 2 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

First Name, Middle Name, Last Name & Suffix	Relationship to you?

Social Security Number **OPTIONAL**	Date of birth (month/day/year)	Sex	Pregnant?
___ ___ ___ - ___ ___ - ___ ___ ___ ___		☐ Male ☐ Female	☐ Yes ☐ No **If yes,** how many babies are expected: ____

Does this PERSON 3 live at the same address as you? ☐ Yes ☐ No **If no,** list address: _____

Does PERSON 3 plan to file a federal income tax return NEXT YEAR?

(You can still apply for health insurance even if you don't file a federal income tax return.)

☐ **YES. If yes,** please answer questions 1–3. ☐ **NO. If no,** skip to question 3.

1. Will PERSON 3 file jointly with a spouse/partner? ☐ Yes ☐ No
   If yes, name of spouse/partner: _____
2. Does PERSON 3 have any dependents? ☐ Yes ☐ No
   If yes, list name(s) of dependents: _____
3. Is PERSON 3 claimed as a dependent on someone else's tax return? ☐ Yes ☐ No
   If yes, please list the name of the tax filer: _____
   How is PERSON 3 related to the tax filer? _____

Is PERSON 3 applying for health insurance?

(Even if you have insurance, there might be a program with better coverage or lower costs.)

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

☐ **NO. If no,** SKIP to the income questions on page 8. Leave the rest of this page blank.

Social Security Number **REQUIRED** if you have one and if not listed above

___ ___ ___ - ___ ___ - ___ ___ ___ ___

Have a disability?	Needs help with activities of daily living through personal assistance services or a medical facility?
☐ Yes ☐ No	☐ Yes ☐ No

U.S. citizen or national?	
☐ Yes ☐ No	**If PERSON 3 isn't a U.S. citizen or national,** do they have eligible immigration status? ☐ Yes Go to page 20 for a list of eligible immigration statuses and add the information below. Document Type: _____ ID Number: _____ Has PERSON 3 lived in the U.S. since 1996? ☐ Yes ☐ No

Does PERSON 3 want help paying for medical bills from the last 3 months? ☐ Yes ☐ No

Does PERSON 3 live with at least one child under the age of 19 and are they the main person taking care of this child? ☐ Yes ☐ No

Please answer the following questions if PERSON 3 is 26 or younger:

Did PERSON 3 have insurance through a job and lose it within the past 3 months? ☐ Yes ☐ No

End date: _____ **Reason the insurance ended:** _____

Is PERSON 3 a full time student?	Was PERSON 3 ever in foster care?	Does PERSON 3 have a parent living outside the home?
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

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

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

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

NOW, tell us about any income from PERSON 3 on the back.

STEP 2: PERSON 3

CURRENT JOB and INCOME INFORMATION

☐ **Not employed**—Skip to "Other Income" lower on this page.

CURRENT JOB 1:

Employer name

Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Monthly ☐ Yearly
$

Average hours worked each WEEK

CURRENT JOB 2: (If you have more jobs and need more space, attach another sheet of paper.)

Employer name

Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Monthly ☐ Yearly
$

Average hours worked each WEEK

In the past 6 months, did PERSON 3:
☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

If self-employed, please answer the following questions:

Type of Work

How much net income (profits once expenses are paid) will PERSON 3 get from this self-employment this month? See instructions on page 20 to see what could be counted.
$

OTHER INCOME: Check all that apply, and give the amount and how often you get it.

NOTE: You don't need to tell us about child support, veteran's payment or Supplemental Security Income (SSI).

☐ None

☐ Unemployment **$** _____ How often? _____

☐ Pensions **$** _____ How often? _____

☐ Social Security **$** _____ How often? _____

☐ Retirement Accounts **$** _____ How often? _____

☐ Alimony **$** _____ How often? _____

☐ Capital Gains **$** _____ How often? _____

☐ Dividends/Interest **$** _____ How often? _____

☐ Net Farming/Fishing **$** _____ How often? _____

☐ Net Rental/Royalty **$** _____ How often? _____

☐ Other Income **$** _____ How often? _____
Type: _____

DEDUCTIONS: Check all that apply, and give the amount and how often you get it.

If PERSON 3 pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health insurance a little lower.

NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment.

☐ Alimony **$** _____ How often? _____

☐ Student loan interest **$** _____ How often? _____

☐ Other deductions **$** _____ How often? _____
Type: _____

YEARLY INCOME:

If the income you listed on this page is not steady from month to month, please tell us what you expect the yearly income to be. For example, some people expect their income to change because they only work some months of the year. If you don't expect changes to your monthly income, skip to Step 3.

PERSON 3's total income **this year**	PERSON 3's total income **next year**
$	**$**

THANKS! This is all we need to know about PERSON 3.

NEED HELP WITH YOUR APPLICATION? Call us at 1-800-XXX-XXXX, or visit us at www.placeholder.gov.
Para obtener una copia de este formulario en Español, llame 1-800-XXX-XXXX.

STEP 2: PERSON 4

Complete Step 2 for your spouse/partner and children who live with you and/or anyone on your same federal income tax return if you file one. See page 2 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

First Name, Middle Name, Last Name & Suffix	Relationship to you?

Social Security Number **OPTIONAL**	Date of birth (month/day/year)	Sex	Pregnant?
___ ___ ___ - ___ ___ - ___ ___ ___ ___		☐ Male ☐ Female	☐ Yes ☐ No **If yes,** how many babies are expected: ____

Does this PERSON 4 live at the same address as you? ☐ Yes ☐ No **If no,** list address: _____

Does PERSON 4 plan to file a federal income tax return NEXT YEAR?

(You can still apply for health insurance even if you don't file a federal income tax return.)

☐ **YES. If yes,** please answer questions 1–3. ☐ **NO. If no,** skip to question 3.

1. Will PERSON 4 file jointly with a spouse/partner? ☐ Yes ☐ No
   If yes, name of spouse/partner: _____
2. Does PERSON 4 have any dependents? ☐ Yes ☐ No
   If yes, list name(s) of dependents: _____
3. Is PERSON 4 claimed as a dependent on someone else's tax return? ☐ Yes ☐ No
   If yes, please list the name of the tax filer: _____
   How is PERSON 4 related to the tax filer? _____

Is PERSON 4 applying for health insurance?

(Even if you have insurance, there might be a program with better coverage or lower costs.)

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

☐ **NO. If no,** SKIP to the income questions on page 10. Leave the rest of this page blank.

Social Security Number **REQUIRED** if you have one and if not listed above

___ ___ ___ - ___ ___ - ___ ___ ___ ___

Have a disability?	Needs help with activities of daily living through personal assistance services or a medical facility?
☐ Yes ☐ No	☐ Yes ☐ No

U.S. citizen or national?	
☐ Yes ☐ No	**If PERSON 4 isn't a U.S. citizen or national,** do they have eligible immigration status? ☐ Yes Go to page 20 for a list of eligible immigration statuses and add the information below. Document Type: _____ ID Number: _____ Has PERSON 4 lived in the U.S. since 1996? ☐ Yes ☐ No

Does PERSON 4 want help paying for medical bills from the last 3 months? ☐ Yes ☐ No

Does PERSON 4 live with at least one child under the age of 19 and are they the main person taking care of this child? ☐ Yes ☐ No

Please answer the following questions if PERSON 4 is 26 or younger:

Did PERSON 4 have insurance through a job and lose it within the past 3 months? ☐ Yes ☐ No

End date: _____ **Reason the insurance ended:** _____

Is PERSON 4 a full time student?	Was PERSON 4 ever in foster care?	Does PERSON 4 have a parent living outside the home?
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

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

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

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

NOW, tell us about any income from PERSON 4 on the back.

STEP 2: PERSON 4

CURRENT JOB and INCOME INFORMATION

☐ **Not employed**—Skip to "Other Income" lower on this page.

CURRENT JOB 1:

Employer name

Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Monthly ☐ Yearly
$

Average hours worked each WEEK

CURRENT JOB 2: (If you have more jobs and need more space, attach another sheet of paper.)

Employer name

Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Monthly ☐ Yearly
$

Average hours worked each WEEK

In the past 6 months, did PERSON 4:
☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

If self-employed, please answer the following questions:

Type of Work

How much net income (profits once expenses are paid) will PERSON 4 get from this self-employment this month? See instructions on page 20 to see what could be counted.
$

OTHER INCOME: Check all that apply, and give the amount and how often you get it.

NOTE: You don't need to tell us about child support, veteran's payment or Supplemental Security Income (SSI).

☐ None

☐ Unemployment **$** _____ How often? _____

☐ Pensions **$** _____ How often? _____

☐ Social Security **$** _____ How often? _____

☐ Retirement Accounts **$** _____ How often? _____

☐ Alimony **$** _____ How often? _____

☐ Capital Gains **$** _____ How often? _____

☐ Dividends/Interest **$** _____ How often? _____

☐ Net Farming/Fishing **$** _____ How often? _____

☐ Net Rental/Royalty **$** _____ How often? _____

☐ Other Income **$** _____ How often? _____
Type: _____

DEDUCTIONS: Check all that apply, and give the amount and how often you get it.

If PERSON 4 pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health insurance a little lower.

NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment.

☐ Alimony **$** _____ How often? _____

☐ Student loan interest **$** _____ How often? _____

☐ Other deductions **$** _____ How often? _____
Type: _____

YEARLY INCOME:

If the income you listed on this page is not steady from month to month, please tell us what you expect the yearly income to be. For example, some people expect their income to change because they only work some months of the year. If you don't expect changes to your monthly income, skip to Step 3.

PERSON 4's total income **this year**	PERSON 4's total income **next year**
$	**$**

THANKS! This is all we need to know about PERSON 4.

STEP 2: PERSON 5

Complete Step 2 for your spouse/partner and children who live with you and/or anyone on your same federal income tax return if you file one. See page 2 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

First Name, Middle Name, Last Name & Suffix	Relationship to you?

Social Security Number **OPTIONAL**	Date of birth (month/day/year)	Sex	Pregnant?
___ ___ ___ - ___ ___ - ___ ___ ___ ___		☐ Male ☐ Female	☐ Yes ☐ No **If yes,** how many babies are expected: ____

Does this PERSON 5 live at the same address as you? ☐ Yes ☐ No **If no,** list address: _____

Does PERSON 5 plan to file a federal income tax return NEXT YEAR?

(You can still apply for health insurance even if you don't file a federal income tax return.)

☐ **YES. If yes,** please answer questions 1–3. ☐ **NO. If no,** skip to question 3.

1. Will PERSON 5 file jointly with a spouse/partner? ☐ Yes ☐ No
   If yes, name of spouse/partner: _____
2. Does PERSON 5 have any dependents? ☐ Yes ☐ No
   If yes, list name(s) of dependents: _____
3. Is PERSON 5 claimed as a dependent on someone else's tax return? ☐ Yes ☐ No
   If yes, please list the name of the tax filer: _____
   How is PERSON 5 related to the tax filer? _____

Is PERSON 5 applying for health insurance?

(Even if you have insurance, there might be a program with better coverage or lower costs.)

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

☐ **NO. If no,** SKIP to the income questions on page 12. Leave the rest of this page blank.

Social Security Number **REQUIRED** if you have one and if not listed above

___ ___ ___ - ___ ___ - ___ ___ ___ ___

Have a disability?	Needs help with activities of daily living through personal assistance services or a medical facility?
☐ Yes ☐ No	☐ Yes ☐ No

U.S. citizen or national?	
☐ Yes ☐ No	**If PERSON 5 isn't a U.S. citizen or national,** do they have eligible immigration status? ☐ Yes Go to page 20 for a list of eligible immigration statuses and add the information below. Document Type: _____ ID Number: _____ Has PERSON 5 lived in the U.S. since 1996? ☐ Yes ☐ No

Does PERSON 5 want help paying for medical bills from the last 3 months? ☐ Yes ☐ No

Does PERSON 5 live with at least one child under the age of 19 and are they the main person taking care of this child? ☐ Yes ☐ No

Please answer the following questions if PERSON 5 is 26 or younger:

Did PERSON 5 have insurance through a job and lose it within the past 3 months? ☐ Yes ☐ No

End date: _____ **Reason the insurance ended:** _____

Is PERSON 5 a full time student?	Was PERSON 5 ever in foster care?	Does PERSON 5 have a parent living outside the home?
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

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

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

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

NOW, tell us about any income from PERSON 5 on the back.

STEP 2: PERSON 5

CURRENT JOB and INCOME INFORMATION

☐ **Not employed**—Skip to "Other Income" lower on this page.

CURRENT JOB 1:

Employer name

Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Monthly ☐ Yearly
$

Average hours worked each WEEK

CURRENT JOB 2: (If you have more jobs and need more space, attach another sheet of paper.)

Employer name

Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Monthly ☐ Yearly
$

Average hours worked each WEEK

In the past 6 months, did PERSON 5:
☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

If self-employed, please answer the following questions:

Type of Work

How much net income (profits once expenses are paid) will PERSON 5 get from this self-employment this month? See instructions on page 20 to see what could be counted.
$

OTHER INCOME: Check all that apply, and give the amount and how often you get it.

NOTE: You don't need to tell us about child support, veteran's payment or Supplemental Security Income (SSI).

☐ None

☐ Unemployment **$** _____ How often? _____

☐ Pensions **$** _____ How often? _____

☐ Social Security **$** _____ How often? _____

☐ Retirement Accounts **$** _____ How often? _____

☐ Alimony **$** _____ How often? _____

☐ Capital Gains **$** _____ How often? _____

☐ Dividends/Interest **$** _____ How often? _____

☐ Net Farming/Fishing **$** _____ How often? _____

☐ Net Rental/Royalty **$** _____ How often? _____

☐ Other Income **$** _____ How often? _____
Type: _____

DEDUCTIONS: Check all that apply, and give the amount and how often you get it.

If PERSON 5 pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health insurance a little lower.

NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment.

☐ Alimony **$** _____ How often? _____

☐ Student loan interest **$** _____ How often? _____

☐ Other deductions **$** _____ How often? _____
Type: _____

YEARLY INCOME:

If the income you listed on this page is not steady from month to month, please tell us what you expect the yearly income to be. For example, some people expect their income to change because they only work some months of the year. If you don't expect changes to your monthly income, skip to Step 3.

PERSON 5's total income **this year**	PERSON 5's total income **next year**
$	**$**

THANKS! This is all we need to know about PERSON 5.

NEED HELP WITH YOUR APPLICATION? Call us at 1-800-XXX-XXXX, or visit us at www.placeholder.gov.
Para obtener una copia de este formulario en Español, llame 1-800-XXX-XXXX.

STEP 2: PERSON 6

Complete Step 2 for your spouse/partner and children who live with you and/or anyone on your same federal income tax return if you file one. See page 2 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

First Name, Middle Name, Last Name & Suffix	Relationship to you?

Social Security Number **OPTIONAL**	Date of birth (month/day/year)	Sex	Pregnant?
___ ___ ___ - ___ ___ - ___ ___ ___ ___		☐ Male ☐ Female	☐ Yes ☐ No **If yes,** how many babies are expected: ____

Does this PERSON 6 live at the same address as you? ☐ Yes ☐ No **If no,** list address: _____

Does PERSON 6 plan to file a federal income tax return NEXT YEAR?

(You can still apply for health insurance even if you don't file a federal income tax return.)

☐ **YES. If yes,** please answer questions 1–3. ☐ **NO. If no,** skip to question 3.

1. Will PERSON 6 file jointly with a spouse/partner? ☐ Yes ☐ No
   If yes, name of spouse/partner: _____
2. Does PERSON 6 have any dependents? ☐ Yes ☐ No
   If yes, list name(s) of dependents: _____
3. Is PERSON 6 claimed as a dependent on someone else's tax return? ☐ Yes ☐ No
   If yes, please list the name of the tax filer: _____
   How is PERSON 1 related to the tax filer? _____

Is PERSON 6 applying for health insurance?

(Even if you have insurance, there might be a program with better coverage or lower costs.)

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

☐ **NO. If no,** SKIP to the income questions on page 4. Leave the rest of this page blank.

Social Security Number **REQUIRED** if you have one and if not listed above

___ ___ ___ - ___ ___ - ___ ___ ___ ___

Have a disability?	Needs help with activities of daily living through personal assistance services or a medical facility?
☐ Yes ☐ No	☐ Yes ☐ No

U.S. citizen or national?	
☐ Yes ☐ No	**If PERSON 6 isn't a U.S. citizen or national,** do they have eligible immigration status? ☐ Yes Go to page 20 for a list of eligible immigration statuses and add the information below. Document Type: _____ ID Number: _____ Has PERSON 6 lived in the U.S. since 1996? ☐ Yes ☐ No

Does PERSON 6 want help paying for medical bills from the last 3 months? ☐ Yes ☐ No

Does PERSON 6 live with at least one child under the age of 19 and are they the main person taking care of this child? ☐ Yes ☐ No

Please answer the following questions if PERSON 6 is 26 or younger:

Did PERSON 6 have insurance through a job and lose it within the past 3 months? ☐ Yes ☐ No

End date: _____ **Reason the insurance ended:** _____

Is PERSON 6 a full time student?	Was PERSON 6 ever in foster care?	Does PERSON 6 have a parent living outside the home?
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

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

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

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

NOW, tell us about any income from PERSON 6 on the back.

STEP 2: PERSON 6

CURRENT JOB and INCOME INFORMATION

☐ **Not employed**—Skip to "Other Income" lower on this page.

CURRENT JOB 1:

Employer name

Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Monthly ☐ Yearly
$

Average hours worked each WEEK

CURRENT JOB 2: (If you have more jobs and need more space, attach another sheet of paper.)

Employer name

Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Monthly ☐ Yearly
$

Average hours worked each WEEK

In the past 6 months, did PERSON 6:
☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

If self-employed, please answer the following questions:

Type of Work

How much net income (profits once expenses are paid) will PERSON 6 get from this self-employment this month? See instructions on page 20 to see what could be counted.
$

OTHER INCOME: Check all that apply, and give the amount and how often you get it.

NOTE: You don't need to tell us about child support, veteran's payment or Supplemental Security Income (SSI).

☐ None

☐ Unemployment **$** _____ How often? _____

☐ Pensions **$** _____ How often? _____

☐ Social Security **$** _____ How often? _____

☐ Retirement Accounts **$** _____ How often? _____

☐ Alimony **$** _____ How often? _____

☐ Capital Gains **$** _____ How often? _____

☐ Dividends/Interest **$** _____ How often? _____

☐ Net Farming/Fishing **$** _____ How often? _____

☐ Net Rental/Royalty **$** _____ How often? _____

☐ Other Income **$** _____ How often? _____
Type: _____

DEDUCTIONS: Check all that apply, and give the amount and how often you get it.

If PERSON 6 pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health insurance a little lower.

NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment.

☐ Alimony **$** _____ How often? _____

☐ Student loan interest **$** _____ How often? _____

☐ Other deductions **$** _____ How often? _____
Type: _____

YEARLY INCOME:

If the income you listed on this page is not steady from month to month, please tell us what you expect the yearly income to be. For example, some people expect their income to change because they only work some months of the year. If you don't expect changes to your monthly income, skip to Step 3.

PERSON 6's total income **this year**	PERSON 6's total income **next year**
$	**$**

THANKS! This is all we need to know about PERSON 6.

NEED HELP WITH YOUR APPLICATION? Call us at 1-800-XXX-XXXX, or visit us at www.placeholder.gov.
Para obtener una copia de este formulario en Español, llame 1-800-XXX-XXXX.

STEP 3

Your Family's Health Insurance

Answer these questions for everyone applying for help paying for health insurance.

INSURANCE FROM JOBS:

Is anyone offered health coverage from a job?

(This includes coverage from someone else's job, such as a parent or spouse, and includes private employer plans as well as TRICARE, federal or state employee plans, and Peace Corps plans.)

☐ **YES. If yes,** answer these questions. If there are plans offered by more than one employer and you need more space, attach another sheet of paper.

Is this a state health benefit plan? ☐ Yes ☐ No ☐ Don't know

☐ **NO. If no,** skip to "Other Health Insurance" on page 16.

Tell us about the job that offers coverage.

We need to know about any health coverage you could get through a job. You can use the Employer Coverage Form on page 21 to get information from the employer about health coverage this job offers to help you complete this section. If there is more than one job, copy this page.

Employee Name	Employee Social Security Number __ __ __ - __ __ - __ __ __ __
Employer Name	Employer Identification Number (EIN)*
Employer Address	Employer Phone Number ( ) –
City / State / Zip Code	
Who can we contact about employee health coverage at this job?	
Phone Number ( ) –	Email Address

*You can ask your employer for this information. See page 21.

What's the name of the lowest cost self-only health plan the employee listed above could enroll in at this job? (Only consider plans that meet the "minimum value standard" set by the Affordable Care Act.)

Name: _____

☐ No plans meet the "minimum value standard" ☐ Don't know

How much would the employee have to pay in premiums for that plan?

$ _____ How Often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly ☐ Other: _____

Do you think the employer's coverage is affordable? ☐ Yes ☐ No

STEP 3

Your Family's Health Insurance (Continued)

Who does this job offer coverage to?

PERSON NAME (First Name, Middle Name, Last Name)	ENROLLED NOW, PLANS TO ENROLL, OR NOT ENROLLED	CHANGES YOU PLAN TO MAKE NEXT YEAR
PERSON 1:	☐ Enrolled Now ☐ Plans to Enroll Start Date: _____ ☐ Not Enrolled	☐ Plans to drop coverage Date: _____ ☐ Will become eligible Start Date: _____
PERSON 2:	☐ Enrolled Now ☐ Plans to Enroll Start Date: _____ ☐ Not Enrolled	☐ Plans to drop coverage Date: _____ ☐ Will become eligible Start Date: _____
PERSON 3:	☐ Enrolled Now ☐ Plans to Enroll Start Date: _____ ☐ Not Enrolled	☐ Plans to drop coverage Date: _____ ☐ Will become eligible Start Date: _____
PERSON 4:	☐ Enrolled Now ☐ Plans to Enroll Start Date: _____ ☐ Not Enrolled	☐ Plans to drop coverage Date: _____ ☐ Will become eligible Start Date: _____
PERSON 5:	☐ Enrolled Now ☐ Plans to Enroll Start Date: _____ ☐ Not Enrolled	☐ Plans to drop coverage Date: _____ ☐ Will become eligible Start Date: _____
PERSON 6:	☐ Enrolled Now ☐ Plans to Enroll Start Date: _____ ☐ Not Enrolled	☐ Plans to drop coverage Date: _____ ☐ Will become eligible Start Date: _____

☐ Check here if this job will no longer offer health coverage next year.

☐ Check here if you think this health insurance will not be affordable next year.

OTHER HEALTH INSURANCE:

Does anyone have another health insurance now, including Veterans, Medicaid or CHIP, Medicare, COBRA, Private/ Other, Retiree Health Plan?

☐ Yes ☐ No **If no,** skip to step 4 on the next page.

WHO HAS OTHER HEALTH INSURANCE?	WHAT TYPE DO THEY HAVE?	NAME OF PLAN	POLICY NUMBER
Name:			
Name:			
Name:			

STEP 4

Is anyone in your family American Indian or Alaska Native (AI/AN)?

☐ **No, nobody in my family is American Indian or Alaska Native**. **If no,** skip to Step 5 on the next page.

☐ **Yes. If yes, continue.**

American Indians and Alaska Natives who enroll in Medicaid, the Children's Health Insurance Program (CHIP), and the Marketplace can also get services from the Indian Health Services, tribal health programs, or urban Indian health programs.

If you or your family members are American Indian or Alaska Native, you may not have to pay cost sharing and may get special monthly enrollment periods. We are asking you to answer the following questions to make sure you and your family get the most help possible.

NOTE: If you need more space please attach another piece of paper.

	AI/AN PERSON 1	AI/AN PERSON 2	AI/AN PERSON 3
Name (First Name, Middle Name, Last Name)	First Middle Last	First Middle Last	First Middle Last
Member of a federally recognized tribe? **If yes**, give the name of the tribe.	☐ Yes _____ ☐ No	☐ Yes _____ ☐ No	☐ Yes _____ ☐ No
Did this person ever get a service from the Indian Health Service, a tribal health program, or urban Indian health program or through a referral from one of these programs?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If no, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs or through a referral from one of these programs?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Certain money received may not be counted for Medicaid or CHIP.

Does the income reported in Step 3, include money from any of the following sources?

☐ Yes ☐ No

If yes, how often and give amount below.

Per capita payments from a tribe that come from natural resources, usage rights, leases or royalties?	☐ Yes $ _____ ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Other ☐ No	☐ Yes $ _____ ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Other ☐ No	☐ Yes $ _____ ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Other ☐ No
Payments from natural resources, farming, ranching, fishing, leases or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations)?	☐ Yes $ _____ ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Other ☐ No	☐ Yes $ _____ ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Other ☐ No	☐ Yes $ _____ ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Other ☐ No
Money from selling things that have cultural significance?	☐ Yes $ _____ ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Other ☐ No	☐ Yes $ _____ ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Other ☐ No	☐ Yes $ _____ ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Other ☐ No

STEP 5

Please read and sign this application.

- I have provided true answers to all the questions on this form to the best of my knowledge. I know that there may be a penalty if I'm not truthful.
- I know that my information on this form will only be used to determine eligibility for health insurance and will be kept private as required by law. I know that I must tell the Health Insurance Marketplace if anything changes (and is different than) what I wrote on this application. I can call **1-800-XXX-XXXX** or visit www.placeholder.gov to report any changes.
- I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex or disability. I can file a complaint of discrimination by visiting www.hhs.gov/ocr/office/file.
- I can confirm that no one applying for health insurance on this application is incarcerated (detained or jailed) or living in a medical facility.

Renewal of Coverage

I understand that if I'm eligible for help paying for health insurance, I may also be able to renew the coverage. During the renewal process, the Health Insurance Marketplace will use income data including information from tax returns of household members. This will determine yearly eligibility for help paying for health insurance for the next 5 years. The Marketplace will send me a notice and let me make changes. If I don't respond, the Marketplace will continue my eligibility at the level indicated by the data. I understand this renewal process will occur each year for the number of years that I check off below, but I may change my choice at any time by contacting the Marketplace.

☐ 5 years ☐ 4 years ☐ 3 years ☐ 2 years ☐ 1 year

☐ Don't renew my eligibility for help paying for health insurance.

If anyone on this application is eligible for Medicaid:

- I know that if Medicaid pays for a medical expense, any money from other health insurance or legal settlements will go to Medicaid to reimburse for these services.
- *For parents who qualify for Medicaid:* I know I will be asked to cooperate with the agency that collects medical support from an absent parent. If I think that cooperating to collect medical support will harm me or my children, I can tell Medicaid and I will not have to cooperate.
- I know that I can be represented in the process by someone other than myself. My eligibility and other important information will be explained to me. I understand that a change in my status could affect the eligibility for a member(s) of my household.

Your right to appeal:

- If I think the Health Insurance Marketplace or Medicaid/CHIP has made a mistake, I can appeal its decision. To appeal means to tell someone at the Health Insurance Marketplace or Medicaid/CHIP that I think the action is wrong, and ask for a fair review of the action. I know that I can find out how to appeal by (State description of process, including phone number). I know that I can be represented in the process by someone other than myself. My eligibility and other important information will be explained to me. I understand that a change in my information could affect the eligibility for member(s) of my household.

Sign this application.

Signature	Date (month/day/year)
Signature	Date (month/day/year)

Congratulations, you're done! What happens next?

We'll let you know what programs you and your family qualify for within 1–2 weeks. You'll get instructions on how to take the next steps to get your health insurance. If you don't hear from us within 2 weeks, call **1-800-XXX-XXXX** or visit www.placeholder.gov.

Filling out this application doesn't obligate you to buy health insurance.

You can choose an authorized representative.

You can give a trusted friend or partner permission to talk about this application with us, see your information and act for you on matters related to this application. This person is called an "authorized representative."

Do you want to name someone as your authorized representative?

☐ Yes ☐ No—Skip to Step 6

Name of Authorized Representative

Address	Apartment Number
City	State / Zip Code

Phone Number

( ) –

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

Your Signature	Date

For certified application counselors and navigators only.

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

Application Start Date

Counselor First Name, Middle Name, Last Name & Suffix

Organization Name	ID Number (if applicable)

STEP 6

Mail completed application.

Mail your signed application to:

Health Insurance Marketplace
1005 XYZ Drive
Washington, DC 20005

Did you remember to:

- ☐ Tell us about everyone in your family & household, even if they don't need insurance? (see page 2 for the list of who to include)
- ☐ Ask your employer about any job-related insurance?
- ☐ Sign this application on page 18.

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 [Insert Time (hours or 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.

Instructions for the Immigration Status and Self-Employment Questions

Eligible Immigration Status list:

Use to answer question about eligible immigration status.

- Lawful Permanent Resident (LPR/Greencard holder)
- Asylee
- Refugee
- Cuban/Haitian Entrant
- Paroled into the U.S.
- Conditional Entrant Granted before 1980
- Battered Spouse, Child and Parent
- Victim of Trafficking and his/her Spouse, Child, Sibling or Parent
- Granted Withholding of Deportation or Withholding of Removal, under the immigration laws and under the Convention against Torture (CAT)
- Individual with Non-immigrant Status (includes worker visas, student visas, and citizens of Micronesia, the Marshall Islands, and Palau)
- Temporary Protected Status (TPS) and Applicant for Temporary Protected Status (TPS)
- Deferred Enforced Departure (DED)
- Deferred Action Status
- Applicant for Special Immigrant Juvenile Status
- Applicant for Adjustment to LPR Status, with Approved Visa Petition
- Applicant for Asylum
- Applicant for Withholding of Deportation or Withholding of Removal, under the immigration laws or under the Convention against Torture (CAT)
- Registry Applicants (with EAD)
- Order of Supervision (with EAD)
- Applicant for Cancellation of Removal or Suspension of Deportation (with EAD)
- Applicant for Legalization under IRCA (with EAD)
- Legalization under the LIFE Act (with EAD)
- Lawful Temporary Resident

For people who are self-employed:

You can subtract the costs below from your gross income to get an amount for your net self-employment income. For more information, see "Instructions for Schedule C" at **www.irs.gov**.

- Car and truck expenses (for travel during the workday, not commuting)
- Depreciation
- Employee wages and fringe benefits
- Property, liability, or business interruption insurance
- Interest (including mortgage interest paid to banks, etc.)
- Legal and professional services
- Rent or lease of business property and utilities
- Commissions, taxes, licenses and fees
- Advertising
- Contract labor
- Repairs and maintenance
- Certain business travel and meals

EMPLOYER COVERAGE FORM

Applying for help with health insurance costs from the Health Insurance Marketplace?

The Health Insurance Marketplace application asks questions about any health coverage available through a current job (even if it's from another person's job, like a parent or spouse) to figure out if you might be able to get help paying for health insurance. Use this form to get the information you need from the employer who offers health coverage. We'll verify this information, so it's important to be accurate. If you have more than one job that offers health coverage, use a separate form for each employer.

EMPLOYEE Information

The **employee** needs to fill out this section. Write down the employee's information then you may request the information below from the employer. Use this completed form when you fill out a Health Insurance Marketplace application.

Employee Name (First, Middle, Last)	Social Security Number
	__ __ __ - __ __ - __ __ __ __

EMPLOYER Information

Ask the **employer** for this information.

Employer Name		Employer Identification Number (EIN) __ __ - __ __ __ __ __ __ __
Employer Address		Employer Phone Number ( ) -
City	State	Zip Code
Who can we contact about employee health coverage at this job?		
Phone Number ( ) -	Email Address	

Tell us about the **health plan** offered by this **employer**.

☐ This employee isn't eligible for coverage under this employer's plan.

The employee is eligible for coverage under this employer's plan on _____ (Start Date).

What's the name of the **lowest** cost self-only health plan this employee could enroll in at this job? (Only consider plans that meet the "minimum value standard" set by the Affordable Care Act.)*

Name: _____

☐ No plans meet the "minimum value standard"

How much would the employee have to pay in premiums for that plan?

$ _____ How Often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly ☐ Other: _____

*According to the standards set by the Affordable Care Act of 2010. If you're not sure, ask your employer or health insurance issuer.

Use the information in this form to complete your Health Insurance Marketplace application.

Apply online at **www.placeholder.gov**, or call us at 1-800-XXX-XXXX to get started.

NEED HELP WITH YOUR APPLICATION? Call us at 1-800-XXX-XXXX, or visit us at www.placeholder.gov.
Para obtener una copia de este formulario en Español, llame 1-800-XXX-XXXX.