Application for Health Insurance

THINGS TO KNOW

Who can use this application?

You can use this application for anyone who needs health insurance.

Apply faster online

You can apply faster online at www.placeholder.gov.

What happens next?

Send your complete, signed application to the address on page 7. If you don't have all the information we ask for, you should sign and submit your application any way.

We'll let you know what you qualify for within 1–2 weeks.

Get help with costs

You need to use a different application to get help with costs. You could 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

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). Visit www.placeholder.gov or call **1-800-XXX-XXXX** to learn more.

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**

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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 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)

We need Social Security Numbers (SSNs) for who has one. We use SSNs to check identity and other information. If someone doesn't have an SSN, call 1-800-XXX-XXXX or visit **www.placeholder.gov**.

Social Security Number ___ ___ ___ - ___ ___ - ___ ___ ___ ___	Sex ☐ Male ☐ Female	Date of birth (month/date/year)

U.S. citizen or national? ☐ Yes ☐ No	**If not a U.S. citizen or national,** do they have eligible immigration status? ☐ Yes Go to page 8 for a list of eligible immigration statuses and add the information below. Document Type: ______________ ID Number: ______________

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
☐ 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

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STEP 2

Tell us about anyone who needs insurance.

Attach additional sheets of paper if you need to.

STEP 2: PERSON 1

First Name, Middle Name, Last Name & Suffix

Relationship to you?

Social Security Number ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Date of birth (month/day/year)

Sex ☐ Male ☐ Female

Does this PERSON 1 live at the same address as you? ☐ Yes ☐ No

If no, list address: ____________________

U.S. citizen or national? ☐ Yes ☐ No

If not a U.S. citizen or national, do they have eligible immigration status? ☐ Yes

Go to page 8 for a list of eligible immigration statuses and add the information below.

Document Type: ____________________ ID Number: ____________________

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
☐ 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 2: PERSON 2

First Name, Middle Name, Last Name & Suffix

Relationship to you?

Social Security Number ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Date of birth (month/day/year)

Sex ☐ Male ☐ Female

Does this PERSON 2 live at the same address as you? ☐ Yes ☐ No

If no, list address: ____________________

U.S. citizen or national? ☐ Yes ☐ No

If not a U.S. citizen or national, do they have eligible immigration status? ☐ Yes

Go to page 8 for a list of eligible immigration statuses and add the information below.

Document Type: ____________________ ID Number: ____________________

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
☐ 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

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STEP 2: PERSON 3

First Name, Middle Name, Last Name & Suffix

Relationship to you?

Social Security Number ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Date of birth (month/day/year)

Sex ☐ Male ☐ Female

Does this PERSON 3 live at the same address as you? ☐ Yes ☐ No

If no, list address: ______________________________

U.S. citizen or national? ☐ Yes ☐ No

If not a U.S. citizen or national, do they have eligible immigration status? ☐ Yes

Go to page 8 for a list of eligible immigration statuses and add the information below.

Document Type: ____________________ ID Number: ____________________

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
☐ 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 2: PERSON 4

First Name, Middle Name, Last Name & Suffix

Relationship to you?

Social Security Number ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Date of birth (month/day/year)

Sex ☐ Male ☐ Female

Does this PERSON 4 live at the same address as you? ☐ Yes ☐ No

If no, list address: ______________________________

U.S. citizen or national? ☐ Yes ☐ No

If not a U.S. citizen or national, do they have eligible immigration status? ☐ Yes

Go to page 8 for a list of eligible immigration statuses and add the information below.

Document Type: ____________________ ID Number: ____________________

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
☐ 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

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STEP 2: PERSON 5

First Name, Middle Name, Last Name & Suffix

Relationship to you?

Social Security Number ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Date of birth (month/day/year)

Sex ☐ Male ☐ Female

Does this PERSON 5 live at the same address as you? ☐ Yes ☐ No

If no, list address: ______________________________

U.S. citizen or national? ☐ Yes ☐ No

If not a U.S. citizen or national, do they have eligible immigration status? ☐ Yes

Go to page 8 for a list of eligible immigration statuses and add the information below.

Document Type: ____________________ ID Number: ____________________

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
☐ 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

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 4. ➔

☐ **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

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STEP 4

Please read and sign this application.

- I have provided true and correct 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).
- I understand that the Health Insurance Marketplace will conduct periodic data checks on the information I've provided here throughout the coverage year and at renewal time to determine whether I remain eligible to be enrolled in a Qualified Health Plan through the Exchange.
- If I think the Health Insurance Marketplace has made a mistake, I can appeal its decision. To appeal means to tell someone at the Health Insurance Marketplace 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)

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Congratulations, you're done! What happens next?

We'll contact you in 1–2 weeks and let you know how to take the next steps, like joining a health plan.

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 5

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

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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 5

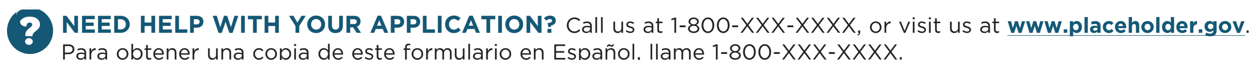
Mail completed application.

Mail your signed application to:

Health Insurance Marketplace
1005 XYZ Drive
Washington, DC 20005

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

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

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