Indiana Application for Health Coverage

State Form 55390 (R9 / 3-21)

FSS405IE001

INSTRUCTIONS: *Please fill out your application as completely as you can. It will help if you can answer all of the questions. Please do not forget to sign your application on Page 1 Section 5.*

1. If you are completing this application on behalf of someone else and you do not live in their household, please provide your name below and your contact information in section 33. If you are completing this application on behalf of someone else and you do live in their household, please provide your information in Section 21:

First Name | MI | Last Name | Suffix

2. Information for person needing assistance: (*additional individuals may be added in Section 21*)

Check the Help This Person Needs: ☐ **Health Coverage** ☐ **Not Applying**

If Health Coverage is checked and you are not eligible for full benefits, do you want to be considered for Family Planning Services only? ☐ Yes ☐ No

If Not Applying is checked, completion of the Social Security Number is optional.

First Name | MI | Last Name | Suffix

Date of Birth (*mm-dd-yyyy*) | Social Security Number | Gender: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

3. Home Address: Number and Street | Apartment/Lot Number

City | State | ZIP Code

County: | Telephone Number:

How many people live at this address including you?

OFFICIAL USE ONLY

4. Mailing Address (*if different than home address*):

City | State | ZIP Code

5. Signature Required

I certify under penalty of perjury, all information I have given on this application, any attachments and information provided during the eligibility determination process is complete and correct to the best of my knowledge and belief, including the citizenship or immigration status of each applicant.

Signature | Date (*mm-dd-yyyy*):

Signature of witness if signed with "X"

Go to the next page

6. Ethnicity/Race *(Optional)*

Ethnicity: Are you Hispanic or Latino? ☐ Yes ☐ No

Race: (*select all that apply*) ☐ White ☐ Black or African American ☐ Asian ☐ Multiracial
☐ American Indian or Alaskan Native ☐ Native Hawaiian or Pacific Islander

If American Indian or Alaska Native, please answer the questions below:

Are you a member of a federally recognized tribe? ☐ Yes ☐ No

If yes, enter tribe name

Have you received 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

If no, are you 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

7. Citizenship/Immigration Information

If not applying is checked, skip to Section 9.

Are you a U.S. citizen or U.S. national? ☐ Yes ☐ No

If no , select your immigration status:

☐ Lawful Permanent Resident ☐ Granted Political Asylum ☐ Parolee ☐ No Documents available

☐ Refugee ☐ Cuban/Haitian Entrant ☐ Amerasian

☐ Other

Date of Status: *(mm-dd-yyyy)* – – Date of entry into the U.S. *(mm-dd-yyyy)* – –

Document Type

Document Number Date of Birth as it appears on the document*(mm-dd-yyyy)*: – –

First Name MI Last Name

Name as it appears on the document:

Country issuing passport *(if using a passport to prove immigration status)*

Are you, or your spouse or parent a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

8. Additional Information For Person Needing Assistance

Do you live with at least one child under the age of eighteen (18), and are you the main person taking care of this child? ☐ Yes ☐ No

Are you Pregnant? ☐ Yes ☐ No If yes, how many babies are expected during this pregnancy?

Pregnancy begin date *(mm-dd-yyyy)*: – – Pregnancy due date *(mm-dd-yyyy)*: – –

Are you blind? ☐ Yes ☐ No Are you disabled? ☐ Yes ☐ No Are you incarcerated? ☐ Yes ☐ No

Are you living in a nursing facility? ☐ Yes ☐ No Are you pending for or receiving a Medicaid Waiver or services from the Program of All-Inclusive Care for the Elderly (PACE)? ☐ Yes ☐ No

Are you living in a Residential Care Facility or Room and Board Facility? ☐ Yes ☐ No

If you are age nineteen (19) or over, are you a full time student? ☐ Yes ☐ No

Go to the next page

Were you in foster care at age eighteen (18)? ☐ Yes ☐ No If Yes, what State was responsible for your foster care?

If you are determined eligible for Presumptive Eligibility (PE), please enter your Presumptive Eligibility Identification Number (PE RID):

9. Tax Filing Information

Are you required to file a Federal Income Tax Return? ☐ Yes ☐ No

Do you plan to file a federal income tax return NEXT YEAR? ☐ Yes ☐ No
(You can still apply for health insurance even if you don't file a federal income tax return.)

If yes, Please answer questions a-c If no, skip to question c

a. Will you file jointly with a spouse? ☐ Yes ☐ No

If yes, does the spouse live in your household? ☐ Yes ☐ No

Name of spouse: First Name MI Last Name

b. Will you claim any dependents on your tax return? ☐ Yes ☐ No

If yes, do the dependents live in your household? ☐ Yes ☐ No

If yes how many dependents live in your household? If no, how many dependents live outside your household?

List name(s) of dependents who live in your household:

Dependent 1 Name First Name MI Last Name

Dependent 2 Name First Name MI Last Name

Dependent 3 Name First Name MI Last Name

Dependent 4 Name First Name MI Last Name

Dependent 5 Name First Name MI Last Name

Dependent 6 Name First Name MI Last Name

c. Will you be claimed as a dependent on someone's tax return? ☐ Yes ☐ No

If yes, please list the name of the tax filer: First Name MI Last Name

How are you related to the tax filer?

Go to the next page

10. Current Employment:

If you are age nineteen (19) or over, are you working at least twenty (20) hours per week? ☐ Yes ☐ No

Name of employer

Employer Address

City

State ZIP Code

Telephone number

Start Date *(mm-dd-yyyy)*

End Date *(mm-dd-yyyy)*

Amount of gross pay per period $

How often paid?

☐ Weekly ☐ Monthly ☐ Bi-weekly ☐ Twice a month

☐ Other:

Hours worked per week

Do hours vary? ☐ Yes ☐ No

Are you self-employed? ☐ Yes ☐ No

If yes, type of work

How much net income (profits once business expenses are paid) will you get from this self-employment this month?

$

Name of employer

Employer Address

City

State ZIP Code

Telephone number

Start Date *(mm-dd-yyyy)*

End Date *(mm-dd-yyyy)*

Amount of gross pay per period $

How often paid?

☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Twice a month

☐ Other:

Hours worked per week

Do hours vary? ☐ Yes ☐ No

Are you self-employed? ☐ Yes ☐ No

If yes, type of work

How much net income (profits once business expenses are paid) will you get from this self-employment this month?

$

Go to the next page

11. Other Income: *check all that apply, and enter the monthly amount.*

Note: Child Support, veteran's benefits, and Supplemental Security Income (SSI) is not counted for many categories of assistance, and you would not need to include unless you are aged, blind, disabled or receiving Medicare.

- ☐ None
- ☐ Unemployment $
- ☐ Pensions $
- ☐ Retirement $
- ☐ Social Security Benefits $
- ☐ Supplemental Security Income (SSI) $
- ☐ Child Support $
- ☐ Alimony received $
- ☐ Canceled Debts $
- ☐ Educational Income $
- ☐ Net farming/fishing $
- ☐ Net rental/royalty $
- ☐ Court Awards $
- ☐ Jury Duty $
- ☐ Investment Income $
- ☐ Capital Gains $
- ☐ Veterans Benefits $
- ☐ Cash Support *(Money from someone other than your parent or spouse)* $

Portion of Educational Income used for general living expenses $

- ☐ Other income $ Type:

12. American Indian/Alaska Native Tribal Income: *check all that apply, and enter the monthly amount.*

If you are American Indian or Alaska Native and a member of a federally recognized tribe, certain money received may not be counted for Medicaid or the Children's Health Insurance Program (CHIP).

Select any income reported on your application that includes money from the following sources:

- Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties
- 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)*
- Money from selling things that have cultural significance
- Money from Scholarship, Award or Fellowship Grant

- ☐ Net farming/fishing $
- ☐ Net rental/royalty $
- ☐ Other income $ Type:
- ☐ Self-employment $
- ☐ Educational Income $

Go to the next page

13. Deductions: *check all that apply, and give the amount and how often amount is deducted.*
If you pay for certain things that can be deducted on a federal income tax return, please indicate them below.
NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment in the Current Employment section.

☐ Alimony paid $ How Often?

☐ Student loan interest $ How Often?

☐ Other deductions $ How Often?

Type:

14. Annual Income

What is your expected annual income for the current year? $

15. Health Coverage Information

Are you enrolled in health coverage now? ☐ Yes ☐ No

If yes, check the type of coverage

☐ Medicare Part A ☐ Medicare Part B ☐ TRICARE ☐ VA health care programs ☐ Peace Corps

☐ Employer insurance

Name of health insurance:

Policy number:

Is this COBRA coverage? ☐ Yes ☐ No

Is this a retiree health plan? ☐ Yes ☐ No

☐ Other

Name of health insurance:

Policy number:

Is this a limited-benefit plan (like a school accident policy)? ☐ Yes ☐ No

If you are a parent or caretaker relative living with a dependent child/children under age nineteen (19), does your child/children receive benefits from Medicaid, Hoosier Healthwise, the Children's Health Insurance Program, or have other health insurance coverage? ☐ Yes ☐ No

Go to the next page

If you are a child under nineteen (19) years of age and applying for Health Coverage, please provide the following information.

Have you lost health insurance coverage in the past three (3) months? ☐ Yes ☐ No

When did coverage end *(mm-dd-yyyy)*? ☐☐-☐☐-☐☐☐☐

Please indicate why coverage was lost by putting a ✓ beside the reason(s).

☐ Loss of employment ☐ Coverage limit reached ☐ Non-custodial parent dropped insurance ☐ Divorce/Death of parent

☐ Could not afford ☐ Company ended coverage ☐ Insurance premium more than 5% of income for child's coverage

☐ Cost of family insurance coverage more than 9.5% of income ☐ Child has special health care needs

☐ Other

16. Tobacco Usage

If you are eligible for the Healthy Indiana Plan (HIP) and you are a tobacco-user, you may have an increased POWER Account contribution in your second year of coverage.

Have you used tobacco four (4) or more times per week in the last six (6) months? (*The definition of tobacco includes: chewing tobacco, cigarettes, cigars, pipes, hookah, and snuff. It does not include the use of nicotine delivery devices.*)

☐ Yes (*If you do not stop using tobacco within the next twelve (12) months you will be assessed a 50% surcharge to your POWER Account contribution. Contact your health plan for help in quitting tobacco*)

☐ No (*FSSA reserves the right to audit claims in order to identify member tobacco use*)

17. Health Plan Selection: (*Please answer this question if anyone is applying for health coverage.*)

We will check your eligibility for all our health coverage categories, if you are eligible for Hoosier Healthwise, the Children's Health Insurance Plan, or the Healthy Indiana Plan (HIP) you will be enrolled in one of our health plans. You do not have to make a selection at this time. If you do not make a plan selection, a plan will be auto-assigned for you based on your prior participation or family member assignment. For Hoosier Healthwise and CHIP, after you have been enrolled in a plan, you will have ninety (90) days to change plans for any reason. After the ninety (90) day period, you can only change plans for reasons that meet the standards for just cause. For HIP, you will be able to change your health plan before you pay your first POWER account contribution for HIP Plus or up to the point when you become enrolled into HIP Basic. In HIP, health plan changes after this period require that you have reasons to meet the standards for just cause.

If you have made your selection, please mark the box next to your chosen plan.

☐ MHS ☐ MDwise ☐ Anthem Blue Cross Blue Shield ☐ CareSource

Provider directories for Hoosier Healthwise are available on the health plan websites. If you have given us your e-mail address, we will send an electronic copy to you.

If you have questions about how to choose your health plan or would like the provider directory before being assigned to a health plan, please call the Hoosier Healthline at 1-800-889-9949.

Go to the next page

18. Hoosier Care Connect Health Plan Selection:(*Please answer this question if anyone is applying for health coverage and is disabled, blind, or age sixty five (65) or older AND not receiving Medicare, Home and Community Based Services, or residing in a long term care facility*).

Hoosier Care Connect is a coordinated health care program for certain aged, blind, and disabled individuals eligible for the Medicaid program. We will check your eligibility for all our health coverage categories, and you may be enrolled in one of our health plans if you qualify. If you do not make a health plan selection on this application, you will have sixty (60) days in which to select a plan after you have been approved for health coverage. If you do not choose a plan within sixty (60) days, a plan will be auto-assigned for you. After you have been enrolled in a plan, you will have ninety (90) days to change plans for any reason. After the ninety (90) day period, you can only change plans for reasons that meet the standards for just cause (quality of care concerns) and annually during your open enrollment period.

If you have made your selection, please mark the box next to your chosen plan.

☐ Anthem Blue Cross Blue Shield ☐ MHS ☐ UnitedHealthcare

If you have questions about how to choose your health plan, please call the Hoosier Healthline at 1-800-889-9949.

19. Is anyone listed on this application offered health coverage from a job? ☐ Yes ☐ No

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

If Yes, complete Section 32, Health Coverage from Jobs

Is this a state employee benefit plan? ☐ Yes ☐ No

20. Contact Information

Work Telephone: ___ - ___ - ____ Alternate Telephone: ___ - ___ - ____

Do you want to receive automated calls from our agency? ☐ Yes ☐ No
(Examples of calls you may receive are appointment reminders or due dates for requested documents)

E-mail address:

Note: Applicants that are aged, blind, disabled may be required to have an interview.

What is your preference for your application interview appointment? ☐ By telephone ☐ At an office

Please indicate if you need the following interpreter services for your application interview appointment:

☐ Language interpreter

Language

☐ Sign Language interpreter

Go to the next page

21. Provide the following information for all other persons who live at the home address in Section 3 and all persons included on your tax return. If you file taxes, we need to know about everyone on your tax return:

- **Person listed in Section 2 does not need to be listed again.**
- **Include person(s) living in an institution who need assistance.**
- **If Not Applying is checked, completion of the Social Security Number is optional.**

Check the Help This Person Needs: ☐ **Health Coverage** ☐ **Not Applying**

If Health Coverage is checked and this person is not eligible for full benefits, does he/she want to be considered for Family Planning Services only? ☐ Yes ☐ No

If Not Applying is checked, completion of the Social Security Number is optional.

First Name | MI | Last Name | Suffix

Date of Birth (*mm-dd-yyyy*) | Social Security Number | Gender: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

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

If no, list their address:

City | State | ZIP Code

Relationship to person needing assistance listed in Section 2:

Ethnicity/Race *(Optional)*

Ethnicity: Is this person Hispanic or Latino? ☐ Yes ☐ No

Race: (*select all that apply*) ☐ White ☐ Black or African American ☐ Asian ☐ Multiracial

☐ American Indian or Alaskan Native ☐ Native Hawaiian or Pacific Islander

If American Indian or Alaska Native, please answer the questions below:

Is this person member of a federally recognized tribe? ☐ Yes ☐ No

If yes, enter tribe name

Has this person ever gotten 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

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

Go to the next page

22. Citizenship/Immigration Information

If not applying is checked, skip to Section 24.

Is this person a U.S. citizen or U.S. national? ☐ Yes ☐ No

If no, select this person's immigration status:

☐ Lawful Permanent Resident ☐ Granted Political Asylum ☐ Parolee ☐ No Documents available

☐ Refugee ☐ Cuban/Haitian Entrant ☐ Amerasian

☐ Other

Date of Status: *(mm-dd-yyyy)* – – Date of entry into the U.S. *(mm-dd-yyyy)* – –

Document Type

Document Number Date of Birth as it appears on the document *(mm-dd-yyyy)*: – –

First Name MI Last Name

Name as it appears on the document:

Country issuing passport *(if using a passport to prove immigration status)*

Is this person, or his/her spouse or parent a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

23. Additional Information For Person Needing Assistance

Does this person live with at least one child under the age of eighteen (18), and is he/she the main person taking care of this child? ☐ Yes ☐ No

Is this person Pregnant? ☐ Yes ☐ No If yes, how many babies are expected during this pregnancy?

Pregnancy begin date *(mm-dd-yyyy)*: – – Pregnancy due date *(mm-dd-yyyy)*: – –

Is this person blind? ☐ Yes ☐ No Is this person disabled? ☐ Yes ☐ No

Is this person incarcerated? ☐ Yes ☐ No

Is this person living in a nursing facility? ☐ Yes ☐ No

Is this person living in a Residential Care Facility or Room and Board Facility? ☐ Yes ☐ No

Is this person pending for or receiving a Medicaid Waiver or services from the Program of All-Inclusive Care for the Elderly (PACE)? ☐ Yes ☐ No

If this person is age nineteen (19) or over, are they a full time student? ☐ Yes ☐ No

Was this person in foster care at age eighteen (18)? ☐ Yes ☐ No If Yes, what State was responsible for this person's foster care?

If this person is determined eligible for Presumptive Eligibility (PE), please enter his/her Presumptive Eligibility Identification Number (PE RID):

Go to the next page

24. Tax Filing Information

Is this person required to file a Federal Income Tax Return? ☐ Yes ☐ No

Does this person plan to file a federal income tax return NEXT YEAR? ☐ Yes ☐ No
(He/she can still apply for health insurance even if he/she doesn't file a federal income tax return.)

If yes, Please answer questions a-c If no, skip to question c

a. Will this person file jointly with a spouse? ☐ Yes ☐ No

If yes, does his/her spouse live in the same household? ☐ Yes ☐ No

	First Name	MI	Last Name
Name of spouse:			

b. Will this person claim any dependents on his/her tax return? ☐ Yes ☐ No

If yes, do the dependents live in this person's household? ☐ Yes ☐ No

If yes, how many dependents live in this person's household? If no, how many dependents live outside this person's household?

List name(s) of dependents who live in this person's household:

	First Name	MI	Last Name
Dependent 1 Name			
Dependent 2 Name			
Dependent 3 Name			
Dependent 4 Name			
Dependent 5 Name			
Dependent 6 Name			

c. Will this person be claimed as a dependent on someone's tax return? ☐ Yes ☐ No

	First Name	MI	Last Name
If yes, please list the name of the tax filer:			

How is this person related to the tax filer?

Go to the next page

25. Current Employment:

If this person is age nineteen (19) or over, are they working at least twenty (20) hours per week? ☐ Yes ☐ No

Name of employer

Employer Address

City

State ZIP Code

Telephone number

Start Date *(mm-dd-yyyy)*

End Date *(mm-dd-yyyy)*

Amount of gross pay per period $

How often paid?

☐ Weekly ☐ Monthly ☐ Bi-weekly ☐ Twice a month

☐ Other:

Hours worked per week

Do hours vary? ☐ Yes ☐ No

Are you self-employed? ☐ Yes ☐ No

If yes, type of work

How much net income (profits once business expenses are paid) will you get from this self-employment this month?

$

Name of employer

Employer Address

City

State ZIP Code

Telephone number

Start Date *(mm-dd-yyyy)*

End Date *(mm-dd-yyyy)*

Amount of gross pay per period $

How often paid?

☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Twice a month

☐ Other:

Hours worked per week

Do hours vary? ☐ Yes ☐ No

Are you self-employed? ☐ Yes ☐ No

If yes, type of work

How much net income (profits once business expenses are paid) will you get from this self-employment this month?

$

Go to the next page

26. Other Income: *check all that apply, and enter the monthly amount.*
Note: Child Support, veteran's benefits, and Supplemental Security Income (SSI) is not counted for many categories of assistance, and you would not need to include unless you are aged, blind, disabled or receiving Medicare.

- ☐ None
- ☐ Unemployment $
- ☐ Pensions $
- ☐ Retirement $
- ☐ Social Security Benefits $
- ☐ Supplemental Security Income (SSI) $
- ☐ Child Support $
- ☐ Alimony received $
- ☐ Canceled Debts $
- ☐ Educational Income $
- ☐ Other income $ Type:
- ☐ Net farming/fishing $
- ☐ Net rental/royalty $
- ☐ Court Awards $
- ☐ Jury Duty $
- ☐ Investment Income $
- ☐ Capital Gains $
- ☐ Veterans Benefits $
- ☐ Cash Support *(Money from someone other than your parent or spouse)* $
- Portion of Educational Income used for general living expenses $

27. American Indian/Alaska Native Tribal Income: *check all that apply, and enter the monthly amount.*
If you are American Indian or Alaska Native and a member of a federally recognized tribe, certain money received may not be counted for Medicaid or the Children's Health Insurance Program (CHIP).

Select any income reported on your application that includes money from the following sources:

- Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties
- 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)*
- Money from selling things that have cultural significance
- Money from Scholarship, Award or Fellowship Grant

- ☐ Net farming/fishing $
- ☐ Net rental/royalty $
- ☐ Other income $ Type:
- ☐ Self-employment $
- ☐ Educational Income $

Go to the next page

28. Deductions: *check all that apply, and give the amount and how often amount is deducted.*
If you pay for certain things that can be deducted on a federal income tax return, please indicate them below.
NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment in the Current Employment section.

☐ Alimony paid $ How Often?

☐ Student loan interest $ How Often?

☐ Other deductions $ How Often?

Type:

29. Annual Income

What is your expected annual income for the current year? $

30. Health Coverage Information

Is this person enrolled in health coverage now? ☐ Yes ☐ No

If yes, check the type of coverage

☐ Medicare Part A ☐ Medicare Part B ☐ TRICARE ☐ VA health care programs ☐ Peace Corps

☐ Employer insurance

Name of health insurance:

Policy number:

Is this COBRA coverage? ☐ Yes ☐ No

Is this a retiree health plan? ☐ Yes ☐ No

☐ Other

Name of health insurance:

Policy number:

Is this a limited-benefit plan (like a school accident policy)? ☐ Yes ☐ No

If this person is a parent or caretaker relative living with a dependent child/children under age nineteen (19), does their child/children receive benefits from Medicaid, Hoosier Healthwise, the Children's Health Insurance Program, or have other health insurance coverage? ☐ Yes ☐ No

Go to the next page

If the applicant is a child under nineteen (19) years of age and applying for Health Coverage, please provide the following information.

Has the applicant lost health insurance coverage in the past three (3) months? ☐ Yes ☐ No

When did coverage end *(mm-dd-yyyy)*? ☐☐-☐☐-☐☐☐☐

Please indicate why coverage was lost by putting a ✓ beside the reason(s).

☐ Loss of employment ☐ Coverage limit reached ☐ Non-custodial parent dropped insurance ☐ Divorce/Death of parent

☐ Could not afford ☐ Company ended coverage ☐ Insurance premium more than 5% of income for child's coverage

☐ Cost of family insurance coverage more than 9.5% of income ☐ Child has special health care needs

☐ Other

31. Tobacco Usage

If you are eligible for the Healthy Indiana Plan (HIP) and you are a tobacco-user, you may have an increased POWER Account contribution in your second year of coverage.

Have you used tobacco four (4) or more times per week in the last six (6) months? (*The definition of tobacco includes: chewing tobacco, cigarettes, cigars, pipes, hookah, and snuff. It does not include the use of nicotine delivery devices.*)

☐ Yes (*If you do not stop using tobacco within the next twelve (12) months you will be assessed a 50% surcharge to your POWER Account contribution. Contact your health plan for help in quitting tobacco*)

☐ No (*FSSA reserves the right to audit claims in order to identify member tobacco use*)

If more than two (2) people live at your address or more than two (2) people are included on your tax return, please provide information on page 19.

Go to the next page

32. Health Coverage from Jobs

You **DON'T** need to answer these questions unless someone in the household is eligible for health coverage from a job.
Tell us about the **job** that offers coverage.

EMPLOYEE Information

First Name | MI | Last Name

Employee Social Security number

EMPLOYER Information

Employer name

Employer Identification number (EIN) | Employer telephone number

Employer address:

City | State | ZIP Code

Who can we contact about employee health coverage at this job?

First Name | MI | Last Name

Telephone number *(if different from above)* | Email address:

Are you currently eligible for coverage offered by this employer, or will you become eligible in the next three (3) months?

☐ Yes *(Continue)* ☐ No *(Stop here and go to Section 33 in the application)*

If you're in a waiting or probationary period, when can you enroll in coverage? (*mm-dd-yyyy*)

List the names of anyone else who is eligible for coverage from this job.

	First Name	MI	Last Name
Name 1			
Name 2			
Name 3			

Go to the next page

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

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

For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? $

b. How often? ☐ Weekly ☐ Every two (2) weeks ☐ Twice a month ☐ Quarterly ☐ Yearly

What change will the employer make for the new plan year *(if known)*?

☐ Employer won't offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* *(Premium should reflect the discount for wellness programs. See previous question)*

a. How much will the employee have to pay in premiums for that plan? $

b. How often? ☐ Weekly ☐ Every two (2) weeks ☐ Twice a month ☐ Quarterly ☐ Yearly

Date of change *(mm-dd-yyyy)* – –

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

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33. If you are completing this application on behalf of someone else, please provide your contact information below:

Street Address

City | State | ZIP Code

Telephone number:

Do you live with the person(s) needing assistance? ☐ Yes ☐ No

If no, what is your relationship to the person(s) needing assistance?

NOTE: If you are a representative for the person(s) needing assistance, the applicant must complete and sign the enclosed Authorized Representative form.

34. Do you want to register to vote? ☐ Yes ☐ No Your answer will not affect your eligibility for health coverage.

35. For Certified Navigators Only

Complete this section if you are a certified Navigator filling out this application for somebody else.

First Name | MI | Last Name | Suffix

Navigator Individual ID number

Organization name

Navigator Organization ID number

Completed by Enrollment Center:

Are you submitting this application as an authorized Enrollment Center? ☐ Yes ☐ No

Date of Application *(mm-dd-yyyy)*