

Application for Health and Dental Insurance Coverage

Who can use this application?

Use this application for yourself and anyone in your household who needs health or dental insurance coverage. People in your household could include a spouse, a child under the age of 27, or a child over the age of 26 if they have a disability.

Apply faster online.

Apply faster online at **MAhealthconnector.org**.

Get help with this application:

Visit **MAhealthconnector.org**.

Call our Customer Service at **1-877 MA ENROLL** (1-877-623-6765) or TTY: 711.

In person: there may be counselors in your area who can help. Visit **MAhealthconnector.org** for more information.

En Español: Llame a nuestro centro de ayuda gratis al **1-877 MA ENROLL** (1-877-623-6765).

If you need help in a language other than English, call **1-877 MA ENROLL** (1-877-623-6765) and tell the Customer Service Representative the language you need. We'll get you help at no cost to you.

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

Sending the application:

Send your complete, signed application to:

**Health Connector Processing Center
P. O. Box 4404
Taunton, MA 02780**

or fax to **617-887-8745**.

Filling out this application doesn't mean you have to buy health coverage.

Get help paying for insurance:

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

You could qualify for:

- A tax credit that can help pay your premiums for health insurance coverage.
- Free or low-cost health insurance plan from MassHealth.
- You may qualify for a free or lower-cost program even if you earn as much as \$156,000 a year (for a family of 4).

If you're not sure what you qualify for, go to **MAhealthconnector.org** and apply online.

STEP 1**Tell us about yourself.**

Choose one adult in the family to be the contact person for your application.

PERSON 1*Please be sure to answer all questions and fill out all parts of this application.*

First name Middle name Last name Suffix

Home address (Not PO box) Check here if you are homeless. Unit or apartment number

City State ZIP code County

Mailing address Check here if same as home address. Unit or apartment number

City State ZIP code County

Best phone number Home Work Cell Other phone number Home Work Cell

Email address:

Do you want to get information about this application by email? Yes NoLanguage you prefer to speak (*if not English*) Language you prefer to write (*if not English*)Do you need health coverage? Yes NoDo you need dental coverage? Yes No**If yes**, have you had dental insurance within the last 12 months? Yes No**If you need health or dental coverage**, answer all the questions below. **If not**, go to Step 2 on page 3.

Social Security number (SSN): ___ ___ ___ / ___ ___ / ___ ___ ___

If you do not have a Social Security number, please choose one of the following reasons: Illness exception Non-citizen exception Just applied Religious exception*We need Social Security numbers (SSNs) for anyone who wants coverage. We use SSNs to verify citizenship. If someone doesn't have an SSN, visit socialsecurity.gov or call 1-800-772-1213.*Are you Male Female Date of birth (*month/day/year*)Are you a U.S. citizen or U.S. national? Yes No**If yes**, are you a naturalized citizen? Yes No Naturalization or citizenship number _____**If you are not a U.S. citizen or U.S. national**, do you have an eligible immigration status?*For more information on acceptable immigration documents, go to MAhealthconnector.org.* Yes. **If yes**, fill in the information about your status and documents below:

Immigration status _____ Immigration document type _____

Document, passport, or card number _____ Passport or document expiration date _____

Alien number _____ Status award date _____

Have you lived in the U.S. since August 22, 1996? Yes NoAre you, or your spouse or parent a veteran or an active-duty member of the U.S. military? Yes NoAre you a resident of Massachusetts? Yes No**If yes**, do you intend to stay in Massachusetts, even if you don't have a fixed address? Yes No**If no**, are you temporarily living outside Massachusetts? Yes No**Questions?**Visit **MAhealthconnector.org** or call **1-877 MA ENROLL** (1-877-623-6765) or TTY: 711, Monday to Friday, 8:00 a.m. to 6:00 p.m.

STEP 2**Tell us about anyone else who needs health or dental insurance coverage.**

If you have more than 4 people to include, make a copy of this page.

PERSON 2

First name	Middle name	Last name	Suffix	Relationship to Person 1
Social Security number (SSN)		Date of birth (<i>month/day/year</i>)		Is Person 2 <input type="checkbox"/> Male? <input type="checkbox"/> Female?

Does Person 2 have the same home and mailing address as Person 1? Yes No **If no**, list address:

Home address (Not PO box) Check here <input type="checkbox"/> if Person 2 is homeless.		Unit or apartment number	
City	State	ZIP code	County
Mailing address Check here <input type="checkbox"/> if same as home address.		Unit or apartment number	
City	State	ZIP code	County

Does Person 2 need health coverage? Yes NoDoes Person 2 need dental coverage? Yes No**If yes**, has Person 2 had dental insurance within the last 12 months? Yes No**If Person 2 needs health or dental coverage**, answer all the questions below. **If not**, go to Person 3 or Step 3.Is Person 2 a U.S. citizen or U.S. national? Yes No**If yes**, is Person 2 a naturalized citizen? Yes No Naturalization or citizenship number _____**If Person 2 is not a U.S. citizen or U.S. national**, do they have an eligible immigration status?*For more information on acceptable immigration documents, go to MAhealthconnector.org.* Yes. **If yes**, fill in the information about their status and documents below:

Immigration status _____ Immigration document type _____

Document, passport, or card number _____ Passport or document expiration date _____

Alien number _____ Status award date _____

Has Person 2 lived in the U.S. since August 22, 1996? Yes NoIs Person 2, or their spouse or parent a veteran or an active-duty member of the U.S. military? Yes NoIs Person 2 a resident of Massachusetts? Yes No**If yes**, do they intend to stay in Massachusetts, even if you don't have a fixed address? Yes No**If no**, are they temporarily living outside Massachusetts? Yes No**Questions?**Visit **MAhealthconnector.org** or call **1-877 MA ENROLL** (1-877-623-6765) or TTY: 711, Monday to Friday, 8:00 a.m. to 6:00 p.m.

STEP 2**Tell us about anyone else who needs health or dental insurance coverage.***(continued)***PERSON 3**

First name	Middle name	Last name	Suffix	Relationship to Person 1
Social Security number (SSN)		Date of birth (month/day/year)		Is Person 3 <input type="checkbox"/> Male? <input type="checkbox"/> Female?

Does Person 3 have the same home and mailing address as Person 1? Yes No **If no**, list address:

Home address (Not PO box) Check here <input type="checkbox"/> if Person 3 is homeless.		Unit or apartment number	
City	State	ZIP code	County
Mailing address Check here <input type="checkbox"/> if same as home address.		Unit or apartment number	
City	State	ZIP code	County

Does Person 3 need health coverage? Yes No

Does Person 3 need dental coverage? Yes No

If yes, has Person 3 had dental insurance within the last 12 months? Yes No

If Person 3 needs health or dental coverage, answer all the questions below. **If not**, go to Person 4 or Step 3.

Is Person 3 a U.S. citizen or U.S. national? Yes No

If yes, is Person 3 a naturalized citizen? Yes No Naturalization or citizenship number _____

If Person 3 is not a U.S. citizen or U.S. national, do they have an eligible immigration status?

For more information on acceptable immigration documents, go to MAhealthconnector.org.

Yes. **If yes**, fill in the information about their status and documents below:

Immigration status _____ Immigration document type _____

Document, passport, or card number _____ Passport or document expiration date _____

Alien number _____ Status award date _____

Has Person 3 lived in the U.S. since August 22, 1996? Yes No

Is Person 3, or their spouse or parent a veteran or an active-duty member of the U.S. military? Yes No

Is Person 3 a resident of Massachusetts? Yes No

If yes, do they intend to stay in Massachusetts, even if you don't have a fixed address? Yes No

If no, are they temporarily living outside Massachusetts? Yes No

Questions?

Visit MAhealthconnector.org or call **1-877 MA ENROLL** (1-877-623-6765) or
TTY: 711, Monday to Friday, 8:00 a.m. to 6:00 p.m.

STEP 2**Tell us about anyone else who needs health or dental insurance coverage.***(continued)***PERSON 4**

First name	Middle name	Last name	Suffix	Relationship to Person 1
Social Security number (SSN)		Date of birth (month/day/year)		Is Person 4 <input type="checkbox"/> Male? <input type="checkbox"/> Female?

Does Person 4 have the same home and mailing address as Person 1? Yes No **If no**, list address:

Home address (Not PO box) Check here <input type="checkbox"/> if Person 4 is homeless.	Unit or apartment number		
City	State	ZIP code	County

Mailing address Check here <input type="checkbox"/> if same as home address.	Unit or apartment number		
City	State	ZIP code	County

Does Person 4 need health coverage? Yes No

Does Person 4 need dental coverage? Yes No

If yes, has Person 4 had dental insurance within the last 12 months? Yes No

If Person 4 needs health or dental coverage, answer all the questions below. **If not**, go to Step 3.

Is Person 4 a U.S. citizen or U.S. national? Yes No

If yes, is Person 4 a naturalized citizen? Yes No Naturalization or citizenship number _____

If Person 4 is not a U.S. citizen or U.S. national, do they have an eligible immigration status?

For more information on acceptable immigration documents, go to MAhealthconnector.org.

Yes. **If yes**, fill in the information about their status and documents below:

Immigration status _____ Immigration document type _____

Document, passport, or card number _____ Passport or document expiration date _____

Alien number _____ Status award date _____

Has Person 4 lived in the U.S. since August 22, 1996? Yes No

Is Person 4, or their spouse or parent a veteran or an active-duty member of the U.S. military? Yes No

Is Person 4 a resident of Massachusetts? Yes No

If yes, do they intend to stay in Massachusetts, even if you don't have a fixed address? Yes No

If no, are they temporarily living outside Massachusetts? Yes No

Questions?

Visit MAhealthconnector.org or call **1-877 MA ENROLL** (1-877-623-6765) or
TTY: 711, Monday to Friday, 8:00 a.m. to 6:00 p.m.

STEP 3**American Indian or Alaska Native (AI/AN) family members**

Are you or is anyone in your family an American Indian or Alaska Native?

- Yes **If yes**, continue. If you have more people to include, make a copy of this page and attach.
 No **If no**, go to Step 4.

▶ AI/AN Person 1

First name	Middle name	Last name	Suffix
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Member of a federally recognized tribe?

- Yes No

If yes, tribe name and state affiliation

▶ AI/AN Person 2

First name	Middle name	Last name	Suffix
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Member of a federally recognized tribe?

- Yes No

If yes, tribe name and state affiliation

STEP 4**Tell us about your tax household**

Do you plan to file a federal income tax return next year?

- No **If no**, go to Step 5.
 Yes **If yes**, list all family members who will be included in your tax return, as well as their tax relationship to you. If you have more people to include, make a copy of this page and attach.

Choose from the following tax relationship terms:

- (Tax filer) Head of Household or Qualified Widow(er)
- (Tax filer) Married, filing jointly
- (Tax filer) Married, filing separately
- Tax Dependent

▶ Tax household Person 1

First name	Middle name	Last name	Suffix
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Tax relationship:

▶ Tax household Person 2

First name	Middle name	Last name	Suffix
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Tax relationship:

Questions?

Visit MAhealthconnector.org or call **1-877 MA ENROLL** (1-877-623-6765) or TTY: 711, Monday to Friday, 8:00 a.m. to 6:00 p.m.

STEP 4**Tell us about your tax household** *(continued)***► Tax household Person 3**

First name	Middle name	Last name	Suffix
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Tax relationship:

► Tax household Person 4

First name	Middle name	Last name	Suffix
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Tax relationship:

STEP 5**Read and sign this application.****Rights and Responsibilities**

This application will be used to determine eligibility for unsubsidized health care administered through the Commonwealth of Massachusetts.

1. The Massachusetts Health Connector may get any records or data to prove any information given on this application and any supplements, or other information you give once you are a member and to support continued eligibility.
2. The Massachusetts Health Connector may get records or data from federal and state data sources and programs, such as the Social Security Administration, the Department of Homeland Security, and the Registry of Motor Vehicles, to prove any information given on this application, or other information once an individual becomes a member, and to support continued eligibility. We will keep all records and data provided to us private, and only use and disclose it in accordance with applicable law.
3. You have consent and authorization from all individuals listed on the application or, if applicable, their parent, guardian, or legally authorized representative, and, as allowed by any legal documents you have submitted with this application, to act on their behalf to complete this application and any ongoing or subsequent eligibility process and activity.
4. You understand your rights and responsibilities and the rights and responsibilities of all persons for whom you are submitting this application, as explained on this signature page.
5. You have or will tell such persons about such rights and responsibilities and the other individuals for whom you are signing also understand their rights and responsibilities.
6. You understand and agree that the Health Connector will treat electronic signatures and faxed signature(s) or copies of signatures with the same force and effect as an original signature(s).
7. The information you have supplied is correct and complete to the best of your knowledge about yourself and other members of your household.
8. You may be subject to penalties under federal law if you intentionally provide false or untrue information.
9. You confirm that no one applying for health insurance on this application is incarcerated (detained or jailed). If someone in this household is in jail, write their name and check one of the following options:

_____ is in jail.

Is this person awaiting trial? Yes No**Questions?**

Visit MAhealthconnector.org or call **1-877 MA ENROLL** (1-877-623-6765) or
TTY: 711, Monday to Friday, 8:00 a.m. to 6:00 p.m.

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STEP 5**Read and sign this application** *(continued)***Sign this application.**

By signing below, you hereby certify under the pains and penalties of perjury that the submissions you have made in this Application are true and complete to the best of your knowledge and you agree to accept and comply with the Rights and Responsibilities above.

The person who filled out Step 1 should sign this application. If you're an Authorized Representative, you may sign here as long as you have completed a separate Authorized Representative Designation (ARD) form.

Signature

Date *(month/day/year)***STEP 6****Mail completed application.**

- Mail your signed application to:
Health Connector Processing Center
P. O. Box 4404
Taunton, MA 02780
FAX: 617-887-8745

Appendix A**Get help completing this application.****You can choose an Authorized Representative.**

You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "Authorized Representative." If you would like to have an authorized representative, download the Authorized Representative Designation (ARD) Form from our website at **MAhealthconnector.org** or call Customer Service at **1-877-MA ENROLL**.

For enrollment assisters only

Complete this section if you are an enrollment assister and filling out this application for someone else. Navigators must fill out a Navigator Designation Form if you have not done so already. Certified Application Counselors must fill out a Certified Application Counselor Designation Form if you have not already done so.

Date *(month/day/year)*Check one: Navigator Certified Application Counselor

First name

Middle name

Last name

Suffix

Organization name

Organization identification number

Questions?

Visit **MAhealthconnector.org** or call **1-877 MA ENROLL** (1-877-623-6765) or TTY: 711, Monday to Friday, 8:00 a.m. to 6:00 p.m.

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