MASSACHUSETTS HEALTH CONNECTOR
the right place for the right plan

Massachusetts Health Connector

IRS Authorization Revocation Form

Use and purpose of this form

This form may be used by people who have authorized the Massachusetts Health Connector to use tax return information from the Internal Revenue Service (IRS) in the Health Connector's yearly redetermination and renewal process.

By requesting financial assistance to help pay for health insurance—such as Advance Premium Tax Credits (APTC), ConnectorCare, or MassHealth—you have authorized the Health Connector to use tax return information from the Internal Revenue Service (IRS) to determine your eligibility for financial assistance in future years.

If you do not want the Health Connector to use your tax return information to complete your redeterminations, you must fill out this form, which will change your application to no longer request financial help paying for health insurance costs.

Once this request is processed, any person on the application currently receiving APTC, ConnectorCare, or MassHealth will lose those benefits, and must pay full price for the health insurance plan in which they are enrolled.

People who choose to change their application to no longer request financial assistance can undo this choice and request financial help again at any time.

How to send this request:

After reviewing and signing this form, mail the completed form to:
Attn: Privacy Officer
Massachusetts Health Connector
P.O. Box 960189
Boston, MA 02196

Or email to **ConnectorPrivacy@state.ma.us**

What happens after you send this request?

The Health Connector may contact you after receiving this request. If you have failed to initial any statement above or to sign, your request will be denied. Once the request is processed and approved, your application will be updated to no longer ask for help paying for health insurance costs and any changes this causes will begin following the dates shown in the Health Connector's Policy NG-5B: Coverage Effective Dates.

STEP 1 Personal Information

Fill out the information below for the primary accountholder.

Please be sure to answer all questions and fill out all parts of this form.

First name	Middle name	Last Name
Home street address (No PO box)		Unit or apartment number
City	State	ZIP code
Best phone number	Date of birth *(month/day/year)*	Last 4 Social Security number (SSN)

STEP 2 Authorization to Change Application

Please read each statement below. If you agree with **each statement**, fill in your initials next to each statement.

Initial here	I no longer authorize the Health Connector to use my IRS information to complete my eligibility determinations in future years during its annual redetermination process.
Initial here	I understand that by revoking this authorization, my application with the Health Connector will be changed to no longer ask for financial help paying for health coverage including Advance Premium Tax Credits (APTC), ConnectorCare, and MassHealth.
Initial here	I understand that all members of my household will lose financial help by changing my application, including any dependents on my health insurance plan and any children eligible for coverage through MassHealth.
Initial here	I understand that because I will no longer be eligible for financial help, I will need to pay full price for any insurance I have through the Health Connector.

STEP 3 Read and sign this form.

By signing below, you agree to the following statement: I have reviewed this form and understand its content. I revoke my authorization to the Health Connector to use my tax return information and I understand that this means I—and any household member on my account—will lose financial help paying for health insurance costs.

Signature	Date *(month/day/year)*

STEP 4	**Special accommodations** The information on this part of the form is not required. Not answering these does not impact your request to the Health Connector.
OPTIONAL	*If you don't need any special accommodations, you don't have to fill out this section.*

Do you need special accommodations for us to communicate with you about this request? (Check all that apply):

☐ Sign language interpreter	Which language?
☐ Foreign language interpreter	Which language?
☐ Other accommodation	Explain

STEP 5	**Mail completed form.**

Mail your completed form to:

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Massachusetts Health Connector
P.O. Box 960189
Boston, MA 02196

Email: ConnectorPrivacy@state.ma.us