10/2016

Application for Exemption from the Shared Responsibility Payment for Individuals who are Unable to Afford Coverage and are in a State with a Federally Facilitated Marketplace

Form Approved
OMB No. 0938-1190

Use this application to apply for an exemption from the shared responsibility payment

- Every person needs to have health coverage or make a payment on his or her federal income tax return. This is called the "shared responsibility payment."
- Some people are eligible for an exemption from making this payment. This application includes one category of exemption. There are other applications for other categories of exemptions. You may apply for certain other categories of exemptions when you file your federal income tax return.
- You don't need to apply for an exemption if you're not going to file a federal income tax return. If you're not sure you'll file a tax return, you may want to apply for an exemption anyway.

Who can use this application?

- **Use this application if you're unable to afford coverage. If you get this exemption, you may be able to buy catastrophic coverage.**
- You can use one single application to ask for this exemption for more than one person in your tax household.

When can you get this exemption?

- Use this application to ask for an exemption for months **in the future**. If you want this exemption for a whole calendar year, you need to request it before the year starts. **You can't get this exemption for time in the past**. If it's after December 31 of the year you need the exemption for, you can apply for this exemption on that year's tax return instead.

What you may need to apply

- Social Security Numbers (SSNs), if you have them.
- Employer and income information for everyone in your tax household (for example, from pay stubs, W-2 forms, or wage and tax statements).
- Information about any job-related health coverage available to your family.
- Proof of your expected yearly household income for the year you need this exemption for. See page 10 for examples of documents you can send.

Why do we ask for this information?

We ask for Social Security Numbers and other information to make sure your exemption is counted when you file your federal income tax return. **We'll keep all the information you give private and secure, as required by law.** To view the Privacy Act Statement, go to HealthCare.gov or see instructions.

Get help with this application

- **Online:** HealthCare.gov.
- **Phone:** Call the Marketplace Call Center at **1-800-318-2596**. TTY users should call **1-855-889-4325**.
- **In person:** There may be counselors in your area who can help. Visit HealthCare.gov, or call the Marketplace Call Center at **1-800-318-2596** for more information.
- **En Español:** Llame a nuestro centro de ayuda gratis al **1-800-318-2596.**
- **Other languages:** If you need help in a language other than English, call **1-800-318-2596** and tell the customer service representative the language you need. We'll get you help at no cost to you.

You have the right to get the information in this product in an alternate format. You also have the right to file a complaint if you feel you've been discriminated against. Visit **www.cms.gov/about-cms/agency-Information/aboutwebsite/cmsnondiscriminationnotice.html**, or call the Marketplace Call Center at **1-800-318-2596** for more information. TTY users should call **1-855-889-4325**.

Please print in capital letters using black or dark blue ink only. Fill in the circles (◯) like this →●.

STEP 1: Tell us about yourself.

(The person who files a federal income tax return in your household should be the contact person for this application. If you're applying for an exemption for a child, we need an adult who claims the child on his or her federal income tax return to fill out this information even if the adult doesn't need the exemption.)

Do you live in Alabama, Alaska, Arizona, Arkansas, Delaware, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Michigan, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Virginia, West Virginia, Wisconsin, or Wyoming?

◯ **YES.** Fill out this application.

◯ **NO.** Visit **HealthCare.gov/exemptions** to get the correct application for people who live in your state. Or call **1-800-318-2596** to find out how to apply for this exemption.

Give your legal name

1. First name	Middle name	Last name	Suffix

2. Home address (Leave blank if you don't have one.)	3. Apartment or suite number

4. City	5. State	6. ZIP code	7. County, parish, or township

8. Mailing address (if different from home address)	9. Apartment or suite number

10. City	11. State	12. ZIP code	13. County, parish, or township

14. Daytime phone number	15. Evening phone number

Please give us a phone number so the Marketplace can contact you if we need more information to process your application.
We won't use your phone number for any other purpose.

16. Do you want to get information by email from the Marketplace? ..... ◯ Yes ◯ No

Email address:

17. What's your preferred spoken language? What's your preferred written language?

STEP 2: Tell us about your tax household.

Who do you need to include on this application?
You need to complete Step 2 for every person in your household who is on the same federal income tax return.

For Person 1:
Person 1 must be an adult who files a federal income tax return in your household, even if they don't want an exemption.

For Person 2:
Person 2 can be either:

- A spouse who files taxes jointly with Person 1.
- Anyone that Person 1 claims as a dependent on the same tax return.

Who not to include:

- A spouse who files taxes separately. Spouses who file separately need to fill out a separate application for themselves and for each person they claim on their tax return.
- Anyone who lives with you but who isn't listed on your tax return. Each person who needs an exemption must be on an application with the person who lists them on a tax return.

If you don't plan to file taxes, you don't need to apply for an exemption.

You'll get an eligibility determination letter in the mail after your application is processed. If you get this exemption, we'll give you an Exemption Certificate Number (ECN) with your approval letter. **Keep the letter for your records.** You'll need to put this number on your federal income tax return at the time you file taxes.

We'll keep all the information you provide private and secure, as required by law. We'll use personal information only to check if you're eligible for an exemption.

STEP 2: PERSON 1 (Start with yourself.)

Person 1 must be the person who files the household federal income tax return, even if the person doesn't need this exemption.

1. First name | Middle name | Last name | Suffix

2. Relationship to you? **SELF**

3. Date of birth (mm/dd/yyyy) ___/___/_____

4. Sex ◯ Male ◯ Female

5. Social Security Number (SSN) ___-___-_____

If you're requesting an exemption for yourself and you have an SSN, you must provide it. You aren't required to have an SSN to get this exemption. If you're not requesting an exemption for yourself, providing your SSN can be helpful because it can speed up the application process. We use SSNs to help make sure that if you get an exemption, it's applied correctly on your taxes. If someone wants help getting an SSN, call **1-800-772-1213** or visit **socialsecurity.gov**. TTY users should call **1-800-325-0778**.

6. **Do you plan to file a federal income tax return?** ◯ Yes ◯ No
   a. Will you file jointly with a spouse? ◯ Yes ◯ No
      If yes, write name of spouse:
   b. Will you claim any dependents on your tax return? ◯ Yes ◯ No
      If yes, list name(s) of dependents:

7. Do you want this exemption? ◯ **YES.** ◯ **NO.**

8. Are you pregnant? ◯ Yes ◯ No a. **If yes,** how many babies are expected during this pregnancy? ☐

9. Do you live with at least one child under the age of 19, and are you the main person taking care of this child? *(Select "yes" if you or your spouse takes care of this child.)* ◯ Yes ◯ No

10. Are you a full-time student? ◯ Yes ◯ No

11. Were you in foster care at age 18 or older? ◯ Yes ◯ No

12. Within the past 6 months, have you used tobacco regularly (4 or more times per week on average excluding religious or ceremonial uses)? ◯ Yes ◯ No

13. Are you a **U.S. citizen** or **U.S. national**? ◯ Yes ◯ No

14. Are you a **naturalized** or **derived citizen**? *(This usually means you were born outside the U.S.)*
◯ **YES. If yes,** complete a and b. ◯ **NO. If no,** continue to question 15.
a. Alien number: b. Certificate number:

15. **If you aren't a U.S. citizen or U.S. national,** do you have eligible immigration status? ◯ **YES.** Enter document type and ID number. *See instructions.*

Immigration document type | Status type (optional) | Write your name as it appears on your immigration document.

Alien or I-94 number | Card number or passport number

SEVIS ID or expiration date (optional) | Other (category code or country of issuance)

a. Have you lived in the U.S. since 1996? ◯ Yes ◯ No
b. Are you, or your spouse or parent, a veteran or an active-duty member of the U.S. military? ◯ Yes ◯ No

Optional: *(Fill in all that apply.)*

16. **If Hispanic/Latino, ethnicity:** ◯ Mexican ◯ Mexican American ◯ Chicano/a ◯ Puerto Rican ◯ Cuban ◯ Other _____

17. **Race:** ◯ White ◯ Black or African American ◯ American Indian or Alaska Native ◯ Filipino ◯ Japanese ◯ Korean ◯ Asian Indian ◯ Chinese ◯ Vietnamese ◯ Other Asian ◯ Native Hawaiian ◯ Guamanian or Chamorro ◯ Samoan ◯ Other Pacific Islander ◯ Other _____

STEP 2: PERSON 1 (Continue with yourself.)

Other health coverage:

18. **Are you enrolled in health coverage now from the following?**

◯ **YES. If yes,** fill in the type of coverage. ◯ **NO.**

Type of coverage:

◯ Employer insurance ◯ COBRA ◯ Medicaid ◯ CHIP ◯ Medicare ◯ TRICARE (Don't check if you have direct care or Line of Duty)
◯ VA health care program ◯ Peace Corps ◯ Other

Is this a retiree health plan? ..... ◯ Yes ◯ No

Is this a limited-benefit plan, like a school accident policy? ..... ◯ Yes ◯ No

19. **Are you offered health coverage from a job?**

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

◯ **YES. If yes,** you'll need to complete and include Appendix A. **Is this a state employee benefit plan?** ..... ◯ Yes ◯ No
◯ **NO.**

20. If your employer withholds some of your wages and uses them to pay for health coverage, list the amount that is withheld each year:

$

Current job & income information

We need to know about any income you have made or expect to make from a job, self-employment, unemployment, retirement, pensions, rental property, fishing/farming, alimony, and Social Security (if taxable). You also need to submit at least one support document for each type of income you list below.

Job 1:

21. Employer name *(as listed on paystub or W-2)*

22. Amount *(wages, tips, commissions, bonuses, or overtime before taxes)*

$

How often?

◯ Hourly ◯ Weekly ◯ Every 2 weeks ◯ Twice a month
◯ Monthly ◯ Quarterly ◯ Semi-annually ◯ Yearly

23. Average hours worked each WEEK

24. When did you start this job? (mm/dd/yyyy)

25. When did/will this job end? (mm/dd/yyyy)

◯ Fill in if this job doesn't have an end date

26. If you don't expect to get this income every month, **write in the year and fill in the month(s)** that you expect to get income from this job:

Year	Month(s) you expect to get job #1 income											
THIS YEAR 20___	◯ January	◯ February	◯ March	◯ April	◯ May	◯ June	◯ July	◯ August	◯ September	◯ October	◯ November	◯ December
NEXT YEAR 20___	◯ January	◯ February	◯ March	◯ April	◯ May	◯ June	◯ July	◯ August	◯ September	◯ October	◯ November	◯ December

STEP 2: PERSON 1 (Continue with yourself.)

Job 2: (If you have more than 2 jobs, make a copy of this page.)

27. Employer name *(as listed on paystub or W-2)*

28. Amount *(wages, tips, commissions, bonuses, or overtime before taxes)* $

How often? ◯ Hourly ◯ Weekly ◯ Every 2 weeks ◯ Twice a month ◯ Monthly ◯ Quarterly ◯ Semi-annually ◯ Yearly

29. Average hours worked each WEEK

30. When did you start this job? (mm/dd/yyyy) ___/___/_____

31. When did/will this job end? (mm/dd/yyyy) ___/___/_____
◯ Fill in if if this job doesn't have an end date

32. If you don't expect to get this income every month, **write in the year and fill in the month(s)** that you expect to get income from this job:

Year	Month(s) you expect to get job #2 income											
THIS YEAR 20__	◯ January	◯ February	◯ March	◯ April	◯ May	◯ June	◯ July	◯ August	◯ September	◯ October	◯ November	◯ December
NEXT YEAR 20__	◯ January	◯ February	◯ March	◯ April	◯ May	◯ June	◯ July	◯ August	◯ September	◯ October	◯ November	◯ December

33. Are you self-employed? ◯ **YES.** ◯ **NO.**

a. Type of work/business name:

b. Amount of net income *(profits after business expenses are paid)* you will get from this self-employment? $

How often? ◯ Weekly ◯ Every 2 weeks ◯ Twice a month ◯ Monthly ◯ Quarterly ◯ Semi-annually ◯ Yearly

34. When did you start this self-employment? (mm/dd/yyyy) ___/___/_____

35. When did/will this self-employment end? (mm/dd/yyyy) ___/___/_____
◯ Fill in if your self-employment doesn't have an end date

36. If you don't expect to get self-employment income every month, **write in the year and fill in the month(s)** that you expect to get this income below. If you have more than one source of self-employment income, make a copy of this page.

Year	Month(s) you expect to get self-employment income											
THIS YEAR 20__	◯ January	◯ February	◯ March	◯ April	◯ May	◯ June	◯ July	◯ August	◯ September	◯ October	◯ November	◯ December
NEXT YEAR 20__	◯ January	◯ February	◯ March	◯ April	◯ May	◯ June	◯ July	◯ August	◯ September	◯ October	◯ November	◯ December

STEP 2: PERSON 1 (Continue with yourself.)

37. **Other income:** Tell us about other income you report on a federal income tax return. List the income type, amount (before taxes), and how often you get it. Some common types of income are listed below. If you have additional income you report on a federal tax return, fill it in under "Other".

NOTE: You don't need to tell us about income that's not reported on a tax return, like child support, veteran's payments, or food stamps. If you get Social Security benefits that are taxable, include the taxable amount listed on your most recent tax return. Don't include amounts for disability benefits, survivor's benefits, old age benefits that aren't taxable, or any Supplemental Security Income (SSI) benefit.

Fill in if you don't expect to get any other income. ◯

Type of income	Amount	How often *(Weekly, Every 2 weeks, Twice a month, Monthly, Quarterly, Semi-annually, Yearly)*	Date started *(mm/dd/yyyy)*	Date ended/ will end *(mm/dd/yyyy)*	Fill in if no expected end date	Number of months you expect to get this income per year
◯ Unemployment	$				◯	
◯ Retirement account withdrawals *(taxable amounts ONLY)*	$				◯	
◯ Pension	$				◯	
◯ Farming/fishing *(net)*	$				◯	
◯ Rental/royalty *(net)*	$				◯	
◯ Alimony received	$				◯	
◯ Social Security *(taxable amount ONLY)*	$				◯	
◯ Other *(write type):*	$				◯	

38. **Deductions:** If you pay for certain things that can be deducted on a federal income tax return (see IRS Form 1040, lines 23-35), fill in information about which deductions you plan to take. Some common types of deductions are listed below. If you have additional deductions from IRS Form 1040, lines 23-35, fill them in under "Other".

Fill in if you don't plan to take any deductions. ◯

Type of deduction	Estimated yearly amount	Did you take this deduction last year?	
◯ Alimony paid	$	◯ Yes	◯ No
◯ IRA deduction	$	◯ Yes	◯ No
◯ Student loan interest paid	$	◯ Yes	◯ No
◯ Other *(write type):*	$	◯ Yes	◯ No

Thanks! This is all we need to know about you.

STEP 2: PERSON 2

Make a copy of Step 2: Person 2 (pages 6, 7, 8 and 9) if there are more than 2 people in your household.

Fill out this page for a spouse who files taxes jointly with you and for anyone you claim as a dependent on your federal income tax return.

1. First name | Middle name | Last name | Suffix

2. Relationship to PERSON 1?

3. Date of birth (mm/dd/yyyy) ☐☐/☐☐/☐☐☐☐

4. Sex ◯ Male ◯ Female

5. Social Security Number (SSN) ☐☐☐-☐☐-☐☐☐☐

If PERSON 2 is requesting an exemption and has an SSN, he or she must provide it. PERSON 2 isn't required to have an SSN to get this exemption. We use SSNs to help make sure that if you get an exemption, it's applied correctly on your taxes. If someone wants help getting an SSN, call **1-800-772-1213** or visit **socialsecurity.gov**. TTY users should call **1-800-325-0778**.

6. **Does PERSON 2 plan to file a federal income tax return?** ◯ Yes ◯ No

If yes, answer 6a and 6b. **If no**, go to question 7.

a. Will PERSON 2 file jointly with a spouse? ◯ Yes ◯ No

If yes, write name of spouse:

b. Will PERSON 2 claim any dependents on his/her tax return? ◯ Yes ◯ No

If yes, list name(s) of dependents:

7. **Will PERSON 2 be claimed as a dependent on PERSON 1's tax return?** ◯ Yes ◯ No

If yes, please list the name of the tax filer:

How is PERSON 2 related to the tax filer?

Note: If PERSON 2 isn't listed on PERSON 1's tax return as a spouse or as a dependent, PERSON 2 must file a separate application.

8. Does PERSON 2 want this exemption? ◯ **YES.** ◯ **NO.**

9. Is PERSON 2 pregnant? ◯ Yes ◯ No a. **If yes,** how many babies are expected during this pregnancy? ☐

10. Does PERSON 2 live with at least one child under the age of 19, and is PERSON 2 the main person taking care of this child? *(Select "yes" if PERSON 2 or their spouse takes care of this child.)* ◯ Yes ◯ No

11. Is PERSON 2 a full-time student? ◯ Yes ◯ No

12. Was PERSON 2 in foster care at age 18 or older? ◯ Yes ◯ No

13. Within the past 6 months, has PERSON 2 used tobacco regularly (4 or more times per week on average excluding religious or ceremonial uses)? ◯ Yes ◯ No

14. Is PERSON 2 a **U.S. citizen** or **U.S. national**? ◯ Yes ◯ No

15. Is PERSON 2 a **naturalized** or **derived citizen**? *(This usually means you were born outside the U.S.)*

◯ **YES. If yes,** complete a and b. ◯ **NO. If no,** continue to question 16.

a. Alien number:

b. Certificate number:

16. **If PERSON 2 isn't a U.S. citizen or U.S. national,** do they have eligible immigration status? ◯ **YES.** Enter document type and ID number. *See instructions.*

Immigration document type | Status type (optional) | Write PERSON 2's name as it appears on their immigration document.

Alien or I-94 number

Card number or passport number

SEVIS ID or expiration date (optional)

Other (category code or country of issuance)

a. Has PERSON 2 lived in the U.S. since 1996? ◯ Yes ◯ No

b. Is PERSON 2, or PERSON 2's spouse or parent, a veteran or an active-duty member of the U.S. military? ◯ Yes ◯ No

Optional: *(Fill in all that apply.)*

17. **If Hispanic/Latino, ethnicity:** ◯ Mexican ◯ Mexican American ◯ Chicano/a ◯ Puerto Rican ◯ Cuban ◯ Other _____

18. **Race:** ◯ White ◯ Black or African American ◯ American Indian or Alaska Native ◯ Filipino ◯ Japanese ◯ Korean ◯ Asian Indian ◯ Chinese ◯ Vietnamese ◯ Other Asian ◯ Native Hawaiian ◯ Guamanian or Chamorro ◯ Samoan ◯ Other Pacific Islander ◯ Other _____

NEED HELP WITH YOUR APPLICATION? Visit HealthCare.gov, or call us at **1-800-318-2596**. Para obtener una copia de este formulario en Español, llame **1-800-318-2596**. If you need help in a language other than English, call **1-800-318-2596** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-855-889-4325**.

STEP 2: PERSON 2 (Continue with PERSON 2.)

Other health coverage:

19. **Is PERSON 2 enrolled in health coverage now from the following?**
◯ **YES. If yes,** fill in the type of coverage. ◯ **NO.**

Type of coverage:
◯ Employer insurance ◯ COBRA ◯ Medicaid ◯ CHIP ◯ Medicare ◯ TRICARE (Don't check if you have direct care or Line of Duty)
◯ VA health care program ◯ Peace Corps ◯ Other

Is this a retiree health plan? ◯ Yes ◯ No

Is this a limited-benefit plan, like a school accident policy? ◯ Yes ◯ No

20. **Is PERSON 2 offered health coverage from a job?**
Select yes even if the coverage is from someone else's job, such as a parent or spouse.
◯ **YES. If yes,** you'll need to complete and include Appendix A. **Is this a state employee benefit plan?** ◯ Yes ◯ No
◯ **NO.**

21. If PERSON 2's employer withholds some of his/her wages and uses them to pay for health coverage, list the amount that is withheld each year:
$

Current job & income information

We need to know about any income PERSON 2 has made or expects to make from a job, self-employment, unemployment, retirement, pensions, rental property, fishing/farming, alimony, and Social Security (if taxable). You also need to submit at least one support document for each type of income you list below.

Job 1:

22. Employer name *(as listed on paystub or W-2)*

23. Amount *(wages, tips, commissions, bonuses, or overtime before taxes)*
$

How often?
◯ Hourly ◯ Weekly ◯ Every 2 weeks ◯ Twice a month
◯ Monthly ◯ Quarterly ◯ Semi-annually ◯ Yearly

24. Average hours worked each WEEK

25. When did PERSON 2 start this job? (mm/dd/yyyy) ___/___/_____

26. When did/will this job end? (mm/dd/yyyy) ___/___/_____
◯ Fill in if this job doesn't have an end date

27. If PERSON 2 doesn't expect to get this income every month, **write in the year and fill in the month(s)** that PERSON 2 expects to get income from this job:

Year	Month(s) PERSON 2 expects to get job #1 income											
THIS YEAR 20___	◯ January	◯ February	◯ March	◯ April	◯ May	◯ June	◯ July	◯ August	◯ September	◯ October	◯ November	◯ December
NEXT YEAR 20___	◯ January	◯ February	◯ March	◯ April	◯ May	◯ June	◯ July	◯ August	◯ September	◯ October	◯ November	◯ December

STEP 2: PERSON 2 (Continue with PERSON 2.)

Job 2: (If PERSON 2 has more than 2 jobs, make a copy of this page.)

28. Employer name *(as listed on paystub or W-2)*

29. Amount *(wages, tips, commissions, bonuses, or overtime before taxes)* $

How often? ◯ Hourly ◯ Weekly ◯ Every 2 weeks ◯ Twice a month ◯ Monthly ◯ Quarterly ◯ Semi-annually ◯ Yearly

30. Average hours worked each WEEK

31. When did PERSON 2 start this job? (mm/dd/yyyy)

32. When did/will this job end? (mm/dd/yyyy)

◯ Fill in if PERSON 2 is still working at this job

33. If PERSON 2 doesn't expect to get this income every month, **write in the year and fill in the month(s)** that PERSON 2 expects to get income from this job:

Year	Month(s) PERSON 2 expects to get job #2 income											
THIS YEAR 20__	◯ January	◯ February	◯ March	◯ April	◯ May	◯ June	◯ July	◯ August	◯ September	◯ October	◯ November	◯ December
NEXT YEAR 20__	◯ January	◯ February	◯ March	◯ April	◯ May	◯ June	◯ July	◯ August	◯ September	◯ October	◯ November	◯ December

34. Is PERSON 2 self-employed? ◯ **YES.** ◯ **NO.**

a. Type of work/business name:

b. Amount of net income *(profits once business expenses are paid)* PERSON 2 will get from this self-employment? $

How often? ◯ Weekly ◯ Every 2 weeks ◯ Twice a month ◯ Monthly ◯ Quarterly ◯ Semi-annually ◯ Yearly

35. When did PERSON 2 start this self-employment? (mm/dd/yyyy)

36. When did/will this self-employment end? (mm/dd/yyyy)

◯ Fill in if PERSON 2's self-employment doesn't have an end date

37. If PERSON 2 doesn't expect to get self-employment income every month, **write in the year and fill in the month(s)** that PERSON 2 expects to get this income below. If PERSON 2 has more than one source of self-employment income, make a copy of this page.

Year	Month(s) PERSON 2 expects to get self-employment income											
THIS YEAR 20__	◯ January	◯ February	◯ March	◯ April	◯ May	◯ June	◯ July	◯ August	◯ September	◯ October	◯ November	◯ December
NEXT YEAR 20__	◯ January	◯ February	◯ March	◯ April	◯ May	◯ June	◯ July	◯ August	◯ September	◯ October	◯ November	◯ December

STEP 2: PERSON 2 (Continue with PERSON 2.)

38. **Other income:** Tell us about other income PERSON 2 reports on a federal income tax return. List the income type, amount (before taxes), and how often received. Some common types of income are listed below. If PERSON 2 has additional income he/she reports on a federal tax return, fill it in under "Other".

NOTE: You don't need to tell us about income that's not reported on a tax return, like child support, veteran's payments, or food stamps. If PERSON 2 gets Social Security benefits that are taxable, include the taxable amount listed on his/her most recent tax return. Don't include amounts for disability benefits, survivor's benefits, old age benefits that aren't taxable, or any Supplemental Security Income (SSI) benefit.

Fill in if PERSON 2 doesn't expect to get any other income. ◯

Type of income	Amount	How often *(Weekly, Every 2 weeks, Twice a month, Monthly, Quarterly, Semi-annually, Yearly)*	Date started *(mm/dd/yyyy)*	Date ended/ will end *(mm/dd/yyyy)*	Fill in if no expected end date	Number of months you expect to get this income per year
◯ Unemployment	$				◯	
◯ Retirement account withdrawals *(taxable amounts ONLY)*	$				◯	
◯ Pension	$				◯	
◯ Farming/fishing *(net)*	$				◯	
◯ Rental/royalty *(net)*	$				◯	
◯ Alimony received	$				◯	
◯ Social Security *(taxable amount ONLY)*	$				◯	
◯ Other *(write type):*	$				◯	

39. **Deductions:** If PERSON 2 pays for certain things that can be deducted on a federal income tax return (see IRS Form 1040, lines 23-35), fill in information about which deductions he/she plans to take. Some common types of deductions are listed below. If PERSON 2 has additional deductions from IRS Form 1040, lines 23-35, fill them in under "Other".

Fill in if PERSON 2 doesn't plan to take any deductions. ◯

Type of deduction	Estimated yearly amount	Did PERSON 2 take this deduction last year?	
◯ Alimony paid	$	◯ Yes	◯ No
◯ IRA deduction	$	◯ Yes	◯ No
◯ Student loan interest paid	$	◯ Yes	◯ No
◯ Other *(write type):*	$	◯ Yes	◯ No

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

STEP 3: Proof of yearly income

You MUST submit proof of each type of income you listed for each person on this application. We can't approve your exemption without proof of income. The table below lists possible documents for each type of income; you may submit other documents not on the list if they are included in the income amount you listed on your application.

If you expect your income to go up or down during the year you are requesting this exemption, you can provide other documents, like a document that states when contract work will end. If any of your income comes from freelance work, you can fill out a self-employment ledger that includes your expected income.

Income Type	Documents
All income types	• A copy of your most recent federal income tax return, Form 1040, if your income and/or deductions listed on this application is similar to your last tax return. Send official documents only — handwritten 1099s and W-2s are not acceptable.
Job	• One or more pay stubs that show the typical pay and hours you work at the job. The pay stubs should show the gross amount and any tips, commissions, bonuses, or overtime pay. • Wages and tax statement (W-2) from the most recent year • 1099-MISC (Non-employee compensation)
Net self-employment	• Self-employment ledger • Schedule C • Form 1120S • Other recent tax document showing self-employment • Copy of a check paid for the self-employment services
Other Income	**Documents**
Unemployment	• Letter from government agency for unemployment benefits. If the document doesn't list the start and end dates, write your best guess at when the benefit will end on the document.
Retirement (taxable amounts ONLY)	• 1099 or relevant tax document that list any withdrawal amounts • Documents showing taxable amount from account withdrawals
Pension	• Pension letter • 1099 or relevant tax document
Rental/royalties (net)	• Lease agreement for land or property you own with lease amount/frequency • Document showing royalty income • 1099-MISC (royalty/rental income fields)
Alimony paid/received	• Court order or legal document showing the monthly alimony amount and the start and end dates (if applicable)
Farming/fishing (net)	• Schedule C • Schedule F • 1099-G
Social Security (taxable amounts ONLY)	• Copy of most recent Form 1040 that shows the taxable amount in line 20b. Don't send copies of your benefit or COLA letter UNLESS the taxable amount is listed on it.

STEP 4: Read & sign this application

- I'm signing this application under penalty of perjury, which means I've given true answers to all the questions on this form to the best of my knowledge. I know that I may be subject to penalties under federal law if I give false and/or untrue information.
- I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting **hhs.gov/ocr/office/file**.

Is anyone applying for an exemption on this application incarcerated (detained or jailed)? ◯ Yes ◯ No

If yes, tell us the person's name. The name of the incarcerated person is:

◯ Fill in here if this person is facing disposition of charges.

We need this information to check your eligibility for an exemption if you choose to apply. We'll check your answers using information in our electronic databases and databases from the Internal Revenue Service (IRS), Social Security, the Department of Homeland Security, and/or a consumer reporting agency. If the information doesn't match, we may ask you to send us proof.

What should I do if I think the results of my exemption application are wrong?

If you don't agree with the results of your exemption application, you can ask for an appeal. Below is important information to consider when requesting an appeal:

- The Health Insurance Marketplace must receive your appeal request within 90 days of the date of the notice of the application results.
- You may have a relative, friend, legal counsel, or another spokesperson, including an Authorized Representative, help you make an appeal request or participate in your appeal. This is optional.
- The outcome of an appeal could change the eligibility of other members of your tax household.

To appeal your exemption application results, visit **HealthCare.gov/marketplace-appeals/**. Or call the Marketplace Call Center at **1-800-318-2596**. TTY users should call **1-855-889-4325**.

PERSON 1 should sign this application. If you're an authorized representative, you may sign here as long as PERSON 1 signed Appendix C. The person who signs this application must be the person who files a federal income tax return and is an adult over the age of 18.

Signature	Date signed (mm/dd/yyyy)
	___ / ___ / ____

STEP 5: Mail completed application

Mail your signed application and documents showing your yearly income (see examples on page 10) to:

Health Insurance Marketplace – Exemption Processing
465 Industrial Blvd.
London, KY 40741

What happens next?

Send your complete, signed application with required documents to the address above. We'll follow up with you within 1–2 weeks. You may receive a call from the Marketplace if we need more information. You'll get an eligibility determination letter in the mail after we process your exemption application. If you qualify for this exemption, we'll give you an Exemption Certificate Number (ECN) that you'll put on your federal income tax return. If you don't hear from us, call the Health Insurance Marketplace Help Center at **1-800-318-2596**. TTY users should call **1-855-889-4325**.

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 0938-1190. The time required to complete this information collection is estimated to average 16 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.

Appendix A

Form Approved
OMB No. 0938-1191

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, even if they don't accept the coverage. Attach a copy of this page for each job that offers coverage.

Tell us about the job that offers coverage.

Make a copy of this page and take it to the employer who offers coverage to help you answer these questions.

EMPLOYEE INFORMATION

1. Employee name (First, Middle, Last)	2. Employee Social Security Number
	___ – ___ – ____

EMPLOYER INFORMATION

3. Employer name	4. Employer Identification Number (EIN)
	__ – _____
5. Employer address	6. Employer phone number
	(___) ___ – ____
7. City	8. State / 9. ZIP code
	__ / _____

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

11. Phone number (if different from above)	12. Email address
(___) ___ – ____	

13. Is the employee currently eligible for coverage offered by this employer, or will the employee become eligible in the next 3 months?

◯ **YES (Continue)** ◯ **NO (Stop here, and return to Step 4 in the application.)**

a. **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.

Name	Name	Name

Tell us about the lowest-cost health plan offered by this employer.

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

15. 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 didn't 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 2 weeks ◯ Twice a month ◯ Once a month ◯ Quarterly ◯ Yearly

16. For the lowest-cost plan that meets the minimum value standard* offered **to the employee and family members requesting an exemption** (only include family plans for family members that do not already have an exemption): If the employer has wellness programs, provide the premium that the employee would pay if they don't get a discount for wellness programs, including smoking cessation programs.

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

b. How often? ◯ Weekly ◯ Every 2 weeks ◯ Twice a month ◯ Once a month ◯ Quarterly ◯ Yearly

17. What change, if any, will the employer make for the new plan year?

◯ Employer won't offer health coverage.

◯ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan that meets the minimum value standard* and is available to the employee only. (Premium should reflect the discount for wellness programs. See question 15.)

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

b. How often? ◯ Weekly ◯ Every 2 weeks ◯ Twice a month ◯ Once a month ◯ Quarterly ◯ Yearly

c. 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% of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986). Most health plans offered by employers meet the minimum value standard.

Appendix C

Form Approved
OMB No. 0938-1191

Assistance with completing this application

For certified application counselors, navigators, agents, and brokers only

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

1. Application start date (mm/dd/yyyy)
   ☐☐/☐☐/☐☐☐☐
2. First name, Middle name, Last name, & Suffix
3. Organization name
4. ID number (if applicable)
5. Agents/Brokers only: NPN number

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 ever need to change or remove your authorized representative, contact the Marketplace. If you're a legally appointed representative for someone on this application, submit proof with the application.

1. Name of authorized representative (First name, Middle name, Last name)
2. Address
3. Apartment or suite number
4. City
5. State
6. ZIP code
7. Phone number
   ☐☐☐ ☐☐☐-☐☐☐☐
8. Organization name
9. ID number (if applicable)

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

10. Signature of PERSON 1 listed on this application

11. Date signed (mm/dd/yyyy)
☐☐/☐☐/☐☐☐☐