MASSACHUSETTS HEALTH CONNECTOR
the right place for the right plan

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: 1-877-623-7773.
- **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:
Massachusetts Health Connector
133 Portland Street, 1st Floor
Boston, MA 02114-1707
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 new 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 low-cost program even if you earn as much as $95,400 a year (for a family of 4). Visit **MAhealthconnector.org** to learn more.

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

Questions?

Visit **MAhealthconnector.org** or call **1-877 MA ENROLL** (1-877-623-6765) or TTY: 1-877-623-7773, Monday to Friday, 8:00 a.m. to 6:00 p.m.

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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 ☐ No

Language you prefer to speak *(if not English)* | Language you prefer to write *(if not English)*

Do you need health coverage? ☐ Yes ☐ No

Do 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 ☐ No

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

Are 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

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 *(month/day/year)*	Is Person 2 ☐ Male? ☐ 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 ☐ if Person 2 is 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

Does Person 2 need health coverage? ☐ Yes ☐ No

Does 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 ☐ No

Is Person 2, or their spouse or parent a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

Is 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

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 ☐ Male? ☐ 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 ☐ if Person 3 is 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

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

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 ☐ Male? ☐ 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 ☐ if Person 4 is 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

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

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

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

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

Tax relationship:

▶ Tax household Person 2

First name | Middle name | Last name | Suffix

Tax relationship:

STEP 4 Tell us about your tax household *(continued)*

▶ Tax household Person 3

First name | Middle name | Last name | Suffix

Tax relationship:

▶ Tax household Person 4

First name | Middle name | Last name | Suffix

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

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:

  Massachusetts Health Connector
  133 Portland Street, 1st Floor
  Boston, MA 02114-1707

  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