Health Insurance Marketplace

Form Approved
OMB No. 0938-1190

Application for Exemption for American Indians and Alaska Natives and Other Individuals who are Eligible to Receive Services from an Indian Health Care Provider

THINGS TO KNOW

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

- Starting in 2014, every person needs to have health coverage or make a payment on their federal income tax return called the "shared responsibility payment."
- Some people are exempt from making this payment. This application includes 2 categories of exemptions. 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. If you're a member of an Indian tribe, you can ask the Internal Revenue Service (IRS) for this exemption when you file your federal income tax return.
- You don't need to ask for an exemption if you're not going to file a federal income tax return because your income is below the filing threshold. If you're not sure, you may want to ask for an exemption.

Who can use this application?

- **Use this application if you and/or anyone in your tax household is:**
  - **A member of an Indian tribe.**
  - **Another individual who's eligible for health services through the Indian Health Service, tribes and tribal organizations, or urban Indian organizations.**
- If you get this exemption, you can keep it for future years without submitting another application if your membership or eligibility for services from an Indian health care provider remains unchanged.
- You can use one application to apply for this exemption for more than one person in your tax household.

What you need to apply

- Documents showing tribal membership or eligibility for services from the Indian Health Service, a tribal health care provider, or an urban Indian health care provider.
- Social Security numbers (SSNs), if you have them.
- Information about people in your tax household.

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.

What happens next?

Send your complete, signed application with documents to the address on page 3. We'll follow-up with you within 1–2 weeks and let you know if we need additional information. If you get this exemption, we'll give you an Exemption Certificate Number that you'll put on your federal income tax return. If you don't hear from us, visit HealthCare.gov, or call the Health Insurance Marketplace Help Center at **1-800-318-2596**. TTY users should call **1-855-889-4325**.

Get help with this application

- **Online:** HealthCare.gov.
- **Phone:** Call our Health Insurance Marketplace Call Center at **1-800-318-2596**.
- **In person:** There may be counselors in your area who can help. Visit HealthCare.gov or call **1-800-318-2596** for more information.
- **En Español:** Llame a nuestro centro de ayuda gratis al **1-800-318-2596**.

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**.

Use blue or black ink to complete this application.

STEP 1 Tell us about yourself.

(We need one adult in the tax household to be the contact person for your application.)

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

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

10. City	11. State	12. ZIP code	13. County

14. Phone number	15. Other phone number
( ) –	( ) –

16. Do you want to get information about this application by email? ☐ Yes ☐ No

Email address: _____

17. What is your preferred spoken or written language (if not English)?

STEP 2 Tell us about your tax household.

Who do you need to include on this application?

Tell us about each person in the tax household who needs an exemption (don't include dependents who aren't asking for this exemption for themselves.) If you get this exemption, we'll give you an Exemption Certificate Number with your approval letter. Keep this for your records. You'll need to put this number on your federal income tax return at the time you file taxes.

Complete Step 2 for each person in your tax household, except for dependents who aren't asking for this exemption for themselves.

Start with yourself, then add all other adults (whether or not they're requesting this exemption) and any dependents, if you want this exemption for them. Make additional copies of page 2 and attach them for each additional person. You don't need to give a Social Security number (SSN) for members of your tax household who don't need this exemption. Someone asking for an exemption may still be eligible for one even if they don't have an SSN. 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

If you have more than one person to include, make a copy of this page and complete.

Complete Step 2 for yourself and/or anyone on your same federal income tax return. Don't fill this out for any dependents who aren't asking for this exemption for themselves.

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

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

3. Sex ☐ Male ☐ Female

4. 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 since it can speed up the application process. We use SSNs to help make sure that if you get an exemption, it is 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**.

5. **Tell us about the federal income tax return that you plan to file.**

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

If yes, name of spouse: _____

b. Will you claim any dependents on your tax return who are requesting this exemption? ☐ Yes ☐ No

If yes, list name(s) of dependents: _____

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: _____

How are you related to the tax filer? _____

6. Do you need this exemption?

☐ **YES.** ☐ **NO.** **If no,** then leave the rest of this page blank.

7. Are you a member of an Indian tribe?

☐ **YES.** If yes, skip to question 9. ☐ **NO.**

8. Are you eligible to get services through an Indian health care provider **only** because you're pregnant with the child of a member of an Indian tribe?

☐ **YES.** If yes, when is your baby (or babies) due (mm/yyyy)?

☐☐ / ☐☐☐☐ then leave the rest of this page blank.

☐ **NO.** If no, skip to the next question.

9. Are you eligible to get services through an Indian health care provider?

☐ **YES.** If yes, answer questions 10 and 11. ☐ **NO.** If no, then leave the rest of this page blank.

10. If you haven't been eligible for services through an Indian health care provider (i.e., spouse of a member of an American Indian or Alaska Native who is eligible for services through the Indian Health Service who wouldn't otherwise be eligible), when did you become eligible for such services (mm/dd/yyyy)?

☐☐ / ☐☐ / ☐☐☐☐

11. If you know that your eligibilty for services through an Indian health care provider has ended or will end (i.e., due to a divorce or will turn 19 years old and wouldn't otherwise be eligible for such services), please provide the date (mm/dd/yyyy).

☐☐ / ☐☐ / ☐☐☐☐

STEP 3 Read & sign this application.

- I'm signing this application under penalty of perjury, which means I've provided 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 provide false and/or untrue information.
- I know that I must tell the Health Insurance Marketplace if anything changes (and is different than) what I wrote on this application. I can call **1-800-318-2596** to report any changes. I understand that a change in my information could affect the eligibility for member(s) of my household.
- 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 **www.hhs.gov/ocr/office/file**.

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

If you don't agree with the results of your exemption application, you can ask for an appeal. Here's 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 can have someone request or participate in your appeal if you want to. That person can be a friend, relative, lawyer, or other individual. Or, you can request and participate in your appeal on your own.
- The outcome of an appeal could change the eligibility of other members of your household.

To appeal the results of your exemption application, call **1-800-318-2596**. TTY users should call **1-855-889-4325**. You can also mail an appeal request form or your own letter requesting an appeal to **Health Insurance Marketplace – Exemption Processing**, 465 Industrial Blvd., London, KY 40741.

Sign this application. 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've provided the required information listed in Appendix A.

Signature	Date (mm/dd/yyyy)
	☐☐ / ☐☐ / ☐☐☐☐

STEP 4 Mail completed application and documents.

Include your documentation showing tribal membership or eligibility for services through the Indian Health Services, a tribal health care provider, or an Urban Indian health care provider, and mail your signed application to:

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

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

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Assistance with 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 ever need to change 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. Your signature

11. Date (mm/dd/yyyy)

/ /

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

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**.