Application for Health and Dental Insurance Coverage

Who can use this application? Use this application for youself and anyone in your tax household who needs health or dental insurance coverage. People in your tax household could include a spouse, 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 **877-623-2155**.

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 Medicaid or the Children's Health Insurance Program (CHIP). You may qualify for a free or low-cost program even if you earn as much as $94,200 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.
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

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

City

State    ZIP code

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): ___ ___ ___ / ___ ___ / ___ ___ ___ ___

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 you are not a U.S. citizen or U.S. national, are you lawfully present in the U.S.?  ☐ Yes  ☐ No

If yes, write your immigration document type

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

and write your immigration document ID number __________________________________________

Are you living in Massachusetts?  ☐ Yes  ☐ No

If yes, do you plan to stay in Massachusetts?  ☐ Yes  ☐ No

If no, are you planning to move to Massachusetts?  ☐ Yes  ☐ No

Are you in jail or prison?  ☐ Yes  ☐ No  If yes, are you (check one below)

☐ Convicted. What is your expected release date? (month/day/year) ___ ___ / ___ ___ / ___ ___ ___ ___

☐ Not convicted. (For example: confined only, awaiting trial)

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.
### 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.

<table>
<thead>
<tr>
<th>PERSON 2</th>
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<tbody>
<tr>
<td>First name</td>
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<table>
<thead>
<tr>
<th>Social Security number (SSN)</th>
<th>Date of birth (month/day/year)</th>
<th>Is Person 2</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>☐ Male? ☐ Female?</td>
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Does Person 2 have the same home and mailing address as Person 1? ☐ Yes ☐ No  **If no,** list address:

<table>
<thead>
<tr>
<th>Home address (Not PO box)</th>
<th>Unit or apartment number</th>
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<tbody>
<tr>
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<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>ZIP code</th>
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<table>
<thead>
<tr>
<th>Mailing address</th>
<th>Check here ☐ if same as home address.</th>
<th>Unit or apartment number</th>
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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 Person 2 is **not** a U.S. citizen or U.S. national, is he or she lawfully present in the U.S.? ☐ Yes ☐ No  **If yes,** write the immigration document type __________________________________________
 For more information on acceptable immigration documents, go to MAhealthconnector.org
 and write the immigration document ID number ________________________________________

Is Person 2 living in Massachusetts? ☐ Yes ☐ No  **If yes,** does he or she plan to stay in Massachusetts? ☐ Yes ☐ No  **If no,** does he or she plan to move to Massachusetts? ☐ Yes ☐ No

Is Person 2 in jail or prison? ☐ Yes ☐ No  **If yes,** is he or she  (**check one below**)  
☐ Convicted. What is your expected release date? (month/day/year) ________/______/______
☐ Not convicted. (**For example: confined only, awaiting trial**)  

**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.
### PERSON 3

<table>
<thead>
<tr>
<th>First name</th>
<th>Middle name</th>
<th>Last name</th>
<th>Suffix</th>
<th>Relationship to Person 1</th>
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<tr>
<th>Social Security number (SSN)</th>
<th>Date of birth (month/day/year)</th>
<th>Is Person 3 Male?</th>
<th>Female?</th>
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Does Person 3 have the same home and mailing address as Person 1?  ☐ Yes  ☐ No  **If no, list address:**

**Home** address (Not PO box)  
City  
Unit or apartment number

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

City  
State  
ZIP code

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 Person 3 is **not** a U.S. citizen or U.S. national, is he or she lawfully present in the U.S.?  ☐ Yes  ☐ No  
**If yes,** write the immigration document type  
For more information on acceptable immigration documents, go to MAhealthconnector.org  
and write the immigration document ID number  

Is Person 3 living in Massachusetts?  ☐ Yes  ☐ No  
If yes, does he or she plan to stay in Massachusetts?  ☐ Yes  ☐ No  
If no, does he or she plan to move to Massachusetts?  ☐ Yes  ☐ No

Is Person 3 in jail or prison?  ☐ Yes  ☐ No  **If yes,** is he or she (check one below)  
☐ Convicted. What is your expected release date? (month/day/year)  
☐ Not convicted. (For example: confined only, awaiting trial)
### STEP 2  
Tell us about anyone else who needs health or dental insurance coverage.  
(continued)

<table>
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<tr>
<th>PERSON 4</th>
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<tbody>
<tr>
<td><strong>First name</strong></td>
</tr>
<tr>
<td>Social Security number (SSN)</td>
</tr>
</tbody>
</table>

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

| **Home address** (Not PO box) | **Unit or apartment number** |
| **City** | **State** | **ZIP code** |

| **Mailing address** | **Check here □ if same as home address.** | **Unit or apartment number** |
| **City** | **State** | **ZIP code** |

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 Person 4 is **not** a U.S. citizen or U.S. national, is he or she lawfully present in the U.S.?  
□ Yes  □ No  
**If yes**, write the immigration document type  
__________________________________________________________

For more information on acceptable immigration documents, go to MAhealthconnector.org  
and write the immigration document ID number  
______________________________________________________________

Is Person 4 living in Massachusetts?  
□ Yes  □ No  
**If yes**, does he or she plan to stay in Massachusetts?  
□ Yes  □ No  
**If no**, does he or she plan to move to Massachusetts?  
□ Yes  □ No

Is Person 4 in jail or prison?  
□ Yes  □ No  **If yes**, is he or she  
(choose one below)

□ Convicted. What is your expected release date?  
(month/day/year)  
___ ___ / ___ ___ / ___ ___ ___ ___

□ Not convicted.  
(For example: confined only, awaiting trial)

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.
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.

### American Indian or Alaska Native (AI/AN) family members

#### AI/AN Person 1

<table>
<thead>
<tr>
<th>First name</th>
<th>Middle name</th>
<th>Last name</th>
<th>Suffix</th>
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</thead>
</table>

Member of a federally recognized tribe?

☐ Yes  ☐ No

If yes, tribe name

#### AI/AN Person 2

<table>
<thead>
<tr>
<th>First name</th>
<th>Middle name</th>
<th>Last name</th>
<th>Suffix</th>
</tr>
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</table>

Member of a federally recognized tribe?

☐ Yes  ☐ No

If yes, tribe name

### Read and sign this application.

- I know that I am signing this application under penalty of perjury, which means I’ve provided true answers to all of the questions to the best of my knowledge. I know that I may be subject to penalties under federal law if I intentionally provide false or untrue information.

- I know that I must tell the Massachusetts Health Connector if anything changes and is different from what I wrote on this application. I can visit MAhealthconnector.org or call 1-877 MA ENROLL (1-877-623-6765) to report any changes. I understand that a change in my information could mean that other members of my household no longer qualify for coverage.

- I know that under federal law, discrimination is not 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.

- I know that the information on this form will only be used to see if I, and others on the application, qualify for health or dental insurance coverage and will be kept private, as required by law.

- I understand that my information will be used to check my qualifications for health or dental coverage. The Connector will check my answers using information in electronic databases such as the Social Security Administration and Department of Homeland Security databases. If the information doesn’t match, I may need to send proof.

### 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 have provided the information required in Appendix A.

<table>
<thead>
<tr>
<th>Signature</th>
<th>Date (month/day/year)</th>
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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.
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 Certified Application Counselors, Navigators, and Brokers only
Complete this section if you’re filling out this application for somebody else. Navigators must fill out a Navigator Designation Form if you have not done so already. Brokers and Certified Application Counselors, please fill out a separate ARD/PSI Form if you do not already have one on file with the Health Connector.

Date (month/day/year)

<table>
<thead>
<tr>
<th>First name</th>
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<th>Last name</th>
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</table>

Organization name

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.