CMS Product No. 11746
March 2014

Instructions to Help You Complete an

Exemption Application at the Health Insurance Marketplace

Starting in 2014, every person needs to have health insurance or make a payment on his or her federal income tax return. This is called the "shared responsibility payment." Some people are exempt from making this payment. Some categories of exemptions are available from the Marketplace, and you'll also see some exemption categories when you file your federal income tax return. Visit **HealthCare.gov/exemptions** for more information on exemptions. At the Marketplace, you can request these exemptions.

EXEMPTION:	SEE THIS PAGE FOR INSTRUCTIONS:
Unable to afford coverage (if you live in a state using **HealthCare.gov**)	**4**
Unable to afford coverage (if you live in certain states with a State-based Marketplace)	**7**
Hardship	**9**
American Indians and Alaska Natives and other individuals who are eligible to receive services from an Indian health care provider	**11**
Membership in recognized religious sects or divisions	**13**
Membership in a health care sharing ministry	**14**
Incarcerated	**15**

For more details on the individual shared responsibility payment, visit **HealthCare.gov/exemptions**.

In most cases, if you qualify for an exemption, you'll need to apply. Which application you use depends on your situation. These instructions include additional help for some of the items in the applications.

NOTE: You don't have to file for an exemption by the end of the open enrollment period for the Marketplace.

REMEMBER: If you get an exemption from the Marketplace, you must keep the letter that the Marketplace sends you with your exemption certificate number (ECN). You'll need this when you file your taxes.

Health Insurance Marketplace

Instructions for General Questions and Information Found on Most of the Applications

Use blue or black ink to complete the application.

STEP 1 Tell us about yourself as the person completing the form.

An adult (18 or older) must complete the contact information in Step 1. We need this information so we can follow up with you if we have questions about your application and so we can let you know if you or someone on the application qualifies for an exemption.

STEP 2 Tell us about your family or tax household.

Start with yourself for each application. Who else you include on the application depends on the type of exemption application you're completing—see your application's specific instructions for further instructions.

PERSON 1 (Start with yourself if you are applying for the exemption)

Items 1–5
Complete the contact information at the top of the page for yourself.

Item 2
If you are including another person on the application, use these relationships to describe how PERSON 2 is related to you:

- Husband/wife
- Domestic partner
- Parent
- Stepparent
- Parent's domestic partner
- Son/daughter
- Stepson/stepdaughter
- Child of domestic partner
- Sibling
- Uncle/aunt
- Nephew/niece
- First cousin
- Grandparent
- Grandchild
- Other relative
- Other unrelated

Item 6
Tell us about the federal income tax return you plan to file next year. If you get an exemption you'll need to file taxes to use it.

- If you plan to file your federal income tax return jointly with your spouse, check "yes" and write his or her name on the line provided. If not, check "no."
- If you will claim any dependents on your tax return, check "yes" and list the names of the dependent(s). If you're filing jointly, list the dependents on Step 2 for each tax filer. If you will not claim any dependents on your tax return, check "no."
- If you're claimed as a dependent, check "yes" and include the name of the tax filer and how you're related. **For example**, if you're the child of the tax filer, list "child." If not, check "no."

PERSON 1 (Continued)

Item 7

Check "yes" if you're applying for an exemption for yourself. Some people will file applications to request an exemption only for someone else. If this applies to you, don't check this box.

The ethnicity and race questions are optional. This information will help the U.S. Department of Health and Human Services (HHS) better understand and improve the health and health care for all Americans. Providing this information won't impact your eligibility for an exemption in any way.

Read & sign this application

Read the statements on page 3 of the application, sign your name, and write today's date. By signing, you're agreeing that the information you provided is true and correct.

If an authorized representative helped you fill out this application, they can sign the form for you, but they'll need to complete the appendix called, "Assistance with Completing this Application," and submit it with your application.

Mail completed application

Once you have completed the application, you can mail your original, signed application (and any appendices or documents that the application says you need to include) to:

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

Be sure to use the correct amount of postage when you mail your application. The postage rate will depend on the weight of your application, which will be based on the number of pages you've included.

The following instructions are for the specific questions and information found on each of the separate applications.

Instructions for Completing the 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

Use this application to apply for an exemption if:

- You can't afford coverage.
- You live in Alabama, Alaska, Arizona, Arkansas, Delaware, Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Louisiana, Maine, Michigan, Mississippi, Missouri, Montana, Nebraska, New Hampshire, New Jersey, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, West Virginia, Wisconsin, or Wyoming.

In order to apply for this exemption, you may need:

- Social Security numbers (SSNs), if you have them
- Employer and income information for everyone in your family (for example, from pay stubs, W-2 forms, or wage and tax statements)
- Information about any job-related health insurance available to your family
- Proof of your yearly income for 2014, such as:
  - Wages and tax statement (W-2)
  - Pay stub
  - Letter from employer
  - Self-employment ledger
  - Cost of living adjustment letter and other benefit verification notices
  - Lease agreement
  - Copy of a check paid to the household member
  - Bank or investment fund statement
  - Document or letter from Social Security Administration (SSA)
  - Form SSA 1099 Social Security benefits statement
  - Letter from government agency for unemployment benefits

  These documents don't necessarily need to be dated for 2014. For example, you can provide recent pay stubs if you don't expect your income to change in 2014. If you expect your income to go up or down in 2014, 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.

STEP 2 Tell us about your family.

(Page 2)

You need to provide information about everyone on your federal income tax return and all family members who live with you. This information helps us make sure everyone gets the exemption they qualify for. **Start with yourself**.

Read the information under "Who do you need to include on this application?" carefully to figure out which people to add in Step 2.

The application has space for up to 2 people. **If you have more than 2 people in your household, make copies of Step 2: PERSON 2** and complete them for each additional person.

Items 8–9

Ethnicity and race questions are optional. This information will help the U.S. Department of Health and Human Services (HHS). Providing this information won't impact your eligibility for an exemption in any way.

PERSON 1: Current job & income information

(Page 3)

We ask about your current income to see if you qualify for an exemption based on coverage being unaffordable. Include information about your current income, including how much you make in wages and tips before taxes are deducted. You don't have to include amounts taken out of your check by your employer for child care, health insurance, or retirement plans that are "not taxable" (sometimes called "pre-tax deductions").

Item 19

If you're self-employed: Fill in the type of work you do and how much net income you'll get this month. Net income means the amount left over after you've taken out business expenses. The amount can be positive or negative. See the list of self-employment income deductions on page 18 of these instructions to find out what you can subtract from your gross income.

Item 21

Deductions: List any of the deductions you're able to claim from the front page of your 1040 federal income tax return.

(Page 4)

Item 24

If anyone in your family is offered health coverage from a job (whether it's their own job or another person's job), check "yes," even if they're offered coverage but aren't currently enrolled. If someone in your family is offered coverage, **you must** complete Appendix A: Health Coverage from Jobs, and submit it with your application. If no, skip to Step 5.

Item 25

If any of the people applying for an exemption are currently enrolled in a type of health coverage listed in item 25 of the application, check the type of coverage, write the person's name next to the coverage they have, and include other information as requested.

Item 32

If you're not a U.S. citizen but have eligible immigration status, check "yes" and provide your document type and document ID number(s) (see pages 16–17 of these instructions). If you have more than one of these documents, list all of them.

PERSON 2

(Pages 5–7)

If PERSON 2 is applying for an exemption, use the same instructions given for PERSON 1 to complete Step 2: PERSON 2.

STEP 3 Read & sign this application.

(Page 8)

Read the statements on this page, sign your name, and write today's date. By signing, you're agreeing that the information you provided is true and correct. If you or someone applying for an exemption on this application is incarcerated (detained or jailed), write their name on the line provided. If the person is pending disposition, mark a check in the box under their name.

If an authorized representative helped you fill out this application, they can sign the form for you, but they'll need to complete Appendix B: Assistance with Completing this Application, and submit it with your application.

APPENDIX A: Exemptions: Health Coverage from Jobs

If anyone in your family has an offer of health coverage from a job, including through a parent or spouse, give information on the offer of coverage, regardless of whether the person is currently enrolled.

Complete one page for each employer that offers health coverage. This appendix includes an Employer Coverage Tool you give to the employer to answer questions about the coverage they offer.

Instructions for Completing the Application for Exemption from the Shared Responsibility Payment for Individuals who are Unable to Afford Coverage and are in Certain States with a State Based Marketplace

Use this application to apply for an exemption if:

- You can't afford coverage.
- You live in California, Colorado, District of Columbia, Hawaii, Kentucky, Maryland, Massachusetts, Minnesota, Nevada, New York, Oregon, Rhode Island, Vermont, or Washington.

STEP 2 Tell us about your family.

(Page 2)

You need to give information about everyone on your federal income tax return even if they aren't applying for an exemption. **Start with yourself**.

The application has space for up to 2 people. **If you have more than 2 people in your household, make copies of Step 2** and complete them for each additional person.

PERSON 1: (Start with yourself)

Items 8–9

Ethnicity and race questions are optional. This information will help the U.S. Department of Health and Human Services (HHS). Providing this information won't impact your eligibility for an exemption in any way.

Item 12

If you're offered health coverage from a job (whether it's your own job or another person's job), check "yes," even if you're offered coverage but aren't currently enrolled. If you're offered coverage, **you must** complete Appendix A: Health Coverage from Jobs, and submit it with your application.

PERSON 2

(Page 3)

If PERSON 2 is applying for an exemption, use the instructions above given for PERSON 1 to complete page Step 2: PERSON 2.

If you have more than 2 people in your household, make copies of page Step 2: PERSON 2 and complete the form for each additional person.

STEP 3 Lowest Cost Marketplace Plan.

(Page 4)

For anyone who is applying for this exemption who isn't offered health coverage through a job, including a spouse or parent's job, your ability to get this exemption is based on the cost of the lowest-cost bronze plan that is available through your state's Marketplace, after applying any tax credits you can get.

STEP 3 (Continued)

This information is only available through your state's Marketplace.

So, if anyone answered "no" to question 12 above—meaning that they aren't offered health coverage through a job—you need to submit an application for health insurance to your state's Marketplace, complete the process, and send us 2 things with this application:

- A copy of the eligibility notice from your state's Marketplace that shows your maximum premium tax credit.
- A copy of the screen from your state's plan comparison tool that shows the premium of the lowest-cost bronze plan available to everyone asking for this exemption. If there isn't a single bronze plan that covers everyone in your tax household asking for an exemption, then send in a copy of the screens showing the lowest-cost bronze plans that add together to have the lowest cost for everyone.

Call your state's Marketplace at the phone number listed in the application if you need help getting this information.

STEP 4 Read & sign this application.

(Page 5)

Read the statements listed on this page, sign your name, and write today's date. By signing, you're agreeing that the information you provided is true and correct.

If an authorized representative helped you fill out this application, they can sign the form for you, but they'll need to complete Appendix B: Assistance with Completing this Application, and submit it with your application.

APPENDIX A: Exemptions: Health Coverage from Jobs

If anyone in your family has an offer of health coverage from a job, including through a parent or spouse, give information on the offer of coverage, regardless of whether the person is currently enrolled.

Complete one page for each employer that offers health coverage. This appendix includes an Employer Coverage Tool you give to the employer to answer questions about the coverage they offer.

Instructions for Completing the Application for Exemption from the Shared Responsibility Payment for Individuals who Experience Hardships

Use this application to apply for an exemption if you've experienced a hardship.

You may qualify for a "hardship" exemption if:

- You were homeless.
- You were evicted in the past 6 months or were facing eviction or foreclosure.
- You received a shut-off notice from a utility company.
- You recently experienced domestic violence.
- You recently experienced the death of a close family member.
- You experienced a fire, flood, or other natural or human-caused disaster that caused substantial damage to your property.
- You filed for bankruptcy in the last 6 months.
- You had medical expenses you couldn't pay in the last 24 months.
- You experienced unexpected increases in necessary expenses due to caring for an ill, disabled, or aging family member.
- You expect to claim a child as a tax dependent who's been denied coverage in Medicaid and the Children's Health Insurance Program (CHIP), and another person is required by court order to give medical support to the child.
- As a result of an eligibility appeals decision, you're eligible for enrollment in a qualified health plan (QHP) through the Marketplace, or lower costs on your monthly premiums, or cost-sharing reductions, for a time period when you weren't enrolled in a QHP through the Marketplace.
- You were determined ineligible for Medicaid because your state didn't expand eligibility for Medicaid under the Affordable Care Act.
- You received a notice saying that your current health insurance plan is being cancelled, and you consider the other plans available unaffordable.
- You experienced another hardship in obtaining health insurance.

STEP 2 Tell us about your tax household.

(Page 3)

You need to give information about anyone in your tax household who needs an exemption. Don't include dependents who aren't asking for an exemption. If you have a tax dependent and you want this exemption for them, fill out a Step 2 for them. **Start with yourself**.

The application has space for up to 2 people. **If you have more than 2 people in your household, make copies of Step 2 (page 3)** and complete them for each additional person who needs an exemption.

Items 8–11

Provide the information requested to explain your hardship. If you have more than one hardship, you'll need to make a copy of Step 2 (page 3) and complete items 8–11 for each one.

Items 12–13

Ethnicity and race questions are optional. This information will help the U.S. Department of Health and Human Services (HHS). Providing this information won't impact your eligibility for an exemption in any way.

STEP 4

If you're requesting a hardship exemption based on coverage being cancelled, and you want to purchase catastrophic coverage, provide this form and documentation to the health insurance company that offers the catastrophic plan you want. If you're requesting a hardship exemption for another reason, or don't want to purchase catastrophic coverage, mail your signed application and any documentation listed on page 1 of the application to the Marketplace at the listed address.

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

Use this application to apply for an exemption if you or anyone in your tax household is:

- A member of an Indian tribe, which includes members of federally recognized tribes and Alaska Natives who are members of an Alaska Native village or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act.
- An American Indian or Alaska Native or other individual who is eligible for health services through the Indian Health Service, tribes and tribal organizations, or urban Indian organizations (referred to as "Indian Health Care Providers" or "I/T/Us"), as described below:
  - **Indians**
    Individuals of Indian descent belonging to the Indian community served by the local facilities and program of the Indian Health Service are eligible for services. An individual may be regarded as within the scope of the Indian Health Service program if he or she is regarded as an Indian by the community in which he or she lives as seen by such factors as tribal membership, enrollment, residence on tax-exempt land, ownership of restricted property, active participation in tribal affairs, or other relevant factors in keeping with general Bureau of Indian Affairs practices in the jurisdiction. Eligibility based on one's status as a California Indian, Eskimo, Aleut, or other Alaska Native is included within this framework.
  - **Non-Indians**
    Additionally, the following non-Indians are eligible for services from the Indian Health Service:

    (A) A child under the age of 19 who is the natural child, adopted child, stepchild, foster child, legal ward, or orphan of an eligible Indian,

    (B) Spouses of an eligible Indian, if the tribe passed a tribal resolution that makes spouses eligible to receive services from the Indian Health Service, or

    (C) Non-Indian women who are pregnant with the child of an eligible Indian.
  - **Urban Indians**
    The Indian Health Service also contracts with urban Indian organizations to provide services to urban populations for which special statutory eligibility criteria apply. To be eligible for the exemption as an urban Indian, an individual must reside in an urban center where an IHS funded urban Indian health program is located and meet one or more of the following four criteria:

    (A) Be a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the state in which they reside, or who is a descendant, in the first or second degree, of any such member,

    (B) Be an Eskimo or Aleut or other Alaska Native,

    (C) Be considered by the Secretary of the Interior to be an Indian for any purpose; or,

    (D) Be determined to be an Indian under regulations promulgated by the Secretary.

STEP 2 Tell us about your tax household.

(Page 2)

Item 7

Check "yes" if you're a member of an Indian tribe. This means you're a member of a federally recognized tribe or are an Alaska Native who is a member of an Alaska Native village or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act (ANSCA). If you answered "yes," you may leave the rest of this page blank. If you're not a member of an Indian tribe, check "no," and go to Item 8.

Item 8

If you're **only** eligible to get services through an Indian health care provider because you're pregnant with a child of a member of a federally recognized tribe or an Alaska Native who is a member of an Alaska Native village or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act (ANSCA), check "yes" and provide your due date. If you answered "no" because you're eligible for services through an Indian health care provider for another reason, go to item 9.

Item 9

Check "yes" if you're eligible to get services through an Indian health care provider, but you're not a member of a federally recognized tribe or an Alaska Native who is a member of an Alaska Native village or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act (ANSCA). Then, answer items 10 and 11, but only if applicable. If these are not applicable, skip to Step 3.

Item 10

If you haven't always been eligible for services through an Indian health care provider, provide the date you became eligible for services. This might apply to you if you gained eligibility through marriage. If this is not applicable to you, leave this item blank.

Item 11

If you know that your eligibility for services through an Indian health care provider has ended or will end, fill in the date when your eligibility for services through an Indian health care provider has or will end. For example, if you're eligible for services because you're the spouse of an American Indian or Alaska Native, and you're in the process of ending your marriage, this will be the date you receive a court order ending your marriage. If you're a non-Indian or Alaska Native child, this might be the date on which you will turn 19 years of age. Then proceed to Step 3.

STEP 3 Read & sign this application.

(Page 3)

Read the statements listed on this page, sign your name, and write today's date. By signing, you're agreeing that the information you provided is true and correct.

If an authorized representative helped you fill out this application, they can sign the form for you, but they'll need to complete Appendix A: Assistance with Completing this Application, and submit it with your application.

Instructions for Completing the Application for Exemption from the Shared Responsibility Payment for Members of Recognized Religious Sects or Divisions

Use this application if you and/or anyone in your tax household is a member of an approved religious sect or division which is described in section 1402(g)(1) of the Internal Revenue Code, and an adherent of established tenets or teachings of such sect or division, including conscientious opposition to acceptance of the benefits of any private or public insurance which makes payments in the event of death, disability, old-age, or retirement or makes payments toward the cost of, or provides services for, medical care (including Medicare and Social Security). These sects or divisions are approved through a process managed by the Social Security Administration.

STEP 2 Tell us about your tax household.

You need to give information about anyone in your tax household who needs an exemption. Don't include dependents who aren't asking for an exemption. If you have a tax dependent and you want this exemption for them, fill out a Step 2 for them. **Start with yourself**.

The application has space for up to 2 people. **If you have more than 2 people in your household, make copies of Step 2 (page 2)** and complete for each additional person.

(Page 2)

Item 8

Check "yes" if you have an approved IRS Form 4029 ("Application for Exemption from Social Security and Medicare Taxes and Waiver of Benefits"), and attach a copy to your application. You don't need to have an approved IRS Form 4029 to get this exemption.

Item 9

Give us the name of your religious sect or division, the district or congregation name, and its address.

Item 10

Give the date you became a member of this religious sect or division. If your religious sect or division doesn't allow children to be members until a certain date, list their birthdate.

Item 11

Give the date you ended your membership if you're not currently a member of this religious sect or division.

Items 12–13

Ethnicity and race questions are optional. This information will help the U.S. Department of Health and Human Services (HHS). Providing this information won't impact your eligibility for an exemption in any way.

STEP 3 Read & sign this application.

(Page 3)

Read the statements listed on this page, sign your name, and write today's date. By signing, you're agreeing that the information you provided is true and correct.

If an authorized representative helped you fill out this application, they can sign the form for you, but they'll need to complete Appendix A: Assistance with Completing this Application, and submit it with your application.

Instructions for Completing the Application for Exemption from the Shared Responsibility Payment for Members of a Health Care Sharing Ministry

Use this application to apply for an exemption if you or anyone in your tax household is/was a member of a health care sharing ministry that is recognized by the Health Insurance Marketplace.

A health care sharing ministry is an organization whose members share a common set of ethical and religious beliefs and share medical expenses among themselves in accordance with these beliefs.

STEP 2 Tell us about your tax household.

You need to give information about anyone in your tax household who needs an exemption. Don't include dependents who aren't asking for an exemption. If you have a tax dependent and you want this exemption for them, fill out a Step 2 for them. **Start with yourself**.

The application has space for up to 2 people. **If you have more than 2 people in your household, make copies of Step 2 (page 2)** and complete for each additional person who needs an exemption.

Item 7

Give the name and address of your health care sharing ministry.

Item 8

Give the dates for when you were a member in good standing. You can only get this exemption for months in the past.

Items 9–10

Ethnicity and race questions are optional. This information will help the U.S. Department of Health and Human Services (HHS). Providing this information won't impact your eligibility for an exemption in any way.

Instructions for Completing the Application for Exemption from the Shared Responsibility Payment for Individuals who are Incarcerated (Detained or Jailed)

Use this application to apply for an exemption if you or anyone in your tax household was or is incarcerated (detained or jailed), other than being held pending disposition of charges.

STEP 2 Tell us about your tax household.

You need to give information about anyone in your tax household who needs an exemption. Don't include dependents who aren't asking for an exemption. **Start with yourself**.

The application has space for up to 2 people. **If you have more than 2 people in your household, make copies of Step 2 (page 2)** and complete for each additional person.

Item 8

Give dates of entry and release for each time period you were incarcerated (detained or jailed) and the name and address of the facility where you were incarcerated. Don't include time periods you were being held pending disposition of charges. You can only get this exemption for months in the past.

Items 9–10

Ethnicity and race questions are optional. This information will help the U.S. Department of Health and Human Services (HHS). Providing this information won't impact your eligibility for an exemption in any way.

Eligible immigration status list:

Use this list to answer questions about eligible immigration status. You only need to tell us about the immigration status for people applying for the following specific exemption: the exemption from the shared responsibility payment for individuals who are unable to afford coverage and are in a state with a federally facilitated Marketplace. If you see your status below, check the box that says "yes."

- Lawful permanent resident (LPR/Green Card holder)
- Asylee
- Refugee
- Cuban/Haitian entrant
- Paroled into the U.S.
- Conditional entrant granted before 1980
- Battered spouse, child, or parent
- Victim of trafficking and his or her spouse, child, sibling, or parent
- Granted Withholding of Deportation or Withholding of Removal, under the immigration laws or under the Convention against Torture (CAT)
- Individual with non-immigrant status (including worker visas, student visas, and citizens of Micronesia, the Marshall Islands, and Palau)
- Temporary Protected Status (TPS)
- Deferred Enforced Departure (DED)
- Deferred Action Status (Deferred Action for Childhood Arrivals (DACA) isn't an eligible immigration status for this purpose.)

- **Applicant for:**
  - Special Immigrant Juvenile Status
  - Adjustment to LPR Status with an approved visa petition
  - Victim of trafficking visa
  - Asylum who has either been granted employment authorization, OR is under 14 and has had an application for asylum pending for at least 180 days.
  - Withholding of Deportation or Withholding of Removal, under the immigration laws or under the Convention against Torture (CAT) who has either been granted employment authorization, OR is under 14 and has had an application for withholding of deportation or withholding of removal under the immigration laws or under the CAT pending for at least 180 days.

- **Certain individuals with employment authorization document:**
  - Registry applicants
  - Order of supervision
  - Applicant for Cancellation of Removal or Suspension of Deportation
  - Applicant for Legalization under IRCA
  - Applicant for Temporary Protected Status (TPS)
  - Legalization under the LIFE Act

- Lawful temporary resident
- Granted an administrative stay of removal by the Department of Homeland Security (DHS)
- Member of a federally recognized Indian tribe or American Indian born in Canada
- Resident of American Samoa

Immigration status and document types:

If you're an eligible non-citizen applying for the exemption from the shared responsibility payment for individuals who are unable to afford coverage and are in a state with a federally facilitated Marketplace, list your immigration document. See the list below for some common document types. If the document you have isn't listed, you can still write its name. If you're not sure, or you have an eligible status but no document, call the Marketplace Call Center at **1-800-318-2596** for help.

IF YOU HAVE:	LIST THESE FOR THE DOCUMENT ID:
Permanent Resident Card, "Green Card" (I-551)	• Alien registration number • Card number
Reentry Permit (I-327)	• Alien registration number
Refugee Travel Document (I-571)	• Alien registration number
Employment Authorization Card (I-766)	• Alien registration number • Card number • Expiration date • Category code
Machine Readable Immigrant Visa (with temporary I-551 language)	• Alien registration number • Passport number
Temporary I-551 Stamp (on passport or 1-94/1-94A)	• Alien registration number
Arrival/Departure Record (I-94/I-94A)	• I-94 number
Arrival/Departure Record in foreign passport (I-94)	• I-94 number • Passport number • Expiration date • Country of issuance
Foreign passport	• Passport number • Expiration date • Country of issuance
Certificate of Eligibility for Nonimmigrant Student Status (I-20)	• SEVIS ID
Certificate of Eligibility for Exchange Visitor Status (DS2019)	• SEVIS ID
Notice of Action (I-797)	• Alien registration number **or** an I-94 number
Other	• Alien registration number **or** an I-94 number • Description of the type or name of the document

You can also list these documents or statuses:

- Document indicating a member of an Indian tribe or American Indian born in Canada
- Office of Refugee Resettlement (ORR) eligibility letter (if under 18)
- Document indicating withholding of removal
- Administrative order staying removal issued by the Department of Homeland Security (DHS)
- Certification from U.S. Department of Health and Human Services (HHS) Office of Refugee Resettlement (ORR)
- Cuban/Haitian entrant
- Resident of American Samoa

For people who are self-employed:

If you have any of these expenses, you can subtract them from your gross income to get an amount for your net self-employment income:

- Car and truck expenses (for travel during the workday, not commuting)
- Employee wages and fringe benefits
- Interest (including mortgage interest paid to banks, etc.)
- Rent or lease of business property and utilities
- Advertising
- Repairs and maintenance
- Deductible self-employment taxes
- Contributions to a self-employed SEP, SIMPLE, or qualified retirement plan
- Property, liability, or business interruption insurance
- Depreciation
- Legal and professional services
- Commissions, taxes, licenses, and fees
- Contract labor
- Certain business travel and meals
- Cost of self-employed health insurance

Assistance with completing this application

- **Certified application counselors, navigators, in-person assistance counselors, and other assisters:**
  - These are professional individuals or organizations trained to help consumers, including help with completing this application. Services are free to consumers. You can ask to see certification showing they're authorized to perform this work. They can help you complete this section. The ID number is the navigator's identification number. This is a unique alphanumeric ID (13 letters and numbers) given to each navigator.
- **Permission for information submitted**
  - By submitting this application, you represent that you have permission from all of the people whose information is on the application to both submit their information to the Marketplace, and receive any communications about their eligibility for an exemption.

Privacy Act Statement

(effective 09/01/2013)

We are authorized to collect the information on this form and any supporting documentation, including social security numbers, under the Patient Protection and Affordable Care Act (Public Law No. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law No. 111-152), and the Social Security Act.

We need the information provided about you and the other individuals listed on this form to determine eligibility for: (1) enrollment in a qualified health plan through the Federal Health Insurance Marketplace, (2) insurance affordability programs (such as Medicaid, CHIP, advanced payment of the premium tax credits, and cost sharing reductions), and (3) certifications of exemption from the individual responsibility requirement. As part of that process, we will verify the information provided on the form, communicate with you or your authorized representative, and eventually provide the information to the health plan you select so that they can enroll any eligible individuals in a qualified health plan or insurance affordability program. We will also use the information provided as part of the ongoing operation of the Marketplace, including activities such as verifying continued eligibility for all programs, processing appeals, reporting on and managing the insurance affordability programs for eligible individuals, performing oversight and quality control activities, combatting fraud, and responding to any concerns about the security or confidentiality of the information.

While providing the requested information (including social security numbers) is voluntary, failing to provide it may delay or prevent your ability to obtain health coverage through the Marketplace, advanced payment of the premium tax credits, cost sharing reductions, or an exemption from the shared responsibility payment. If you don't have an exemption from the shared responsibility payment and you don't maintain qualifying health coverage for three months or longer during the year, you may be subject to a penalty. If you don't provide correct information on this form or knowingly and willfully provide false or fraudulent information, you may be subject to a penalty and other law enforcement action.

In order to verify and process applications, determine eligibility, and operate the Marketplace, we will need to share selected information that we receive outside of CMS, including to:

1. Other federal agencies, (such as the Internal Revenue Service, Social Security Administration and Department of Homeland Security), State agencies (such as Medicaid or CHIP) or local government agencies. We may use the information you provide in computer matching programs with any of these groups to make eligibility determinations, to verify continued eligibility for enrollment in a qualified health plan or Federal benefit programs, or to process appeals of eligibility determinations;
2. Other verification sources including consumer reporting agencies;
3. Employers identified on applications for eligibility determinations;
4. Applicants/enrollees, and authorized representatives of applicants/enrollees;
5. Agents, Brokers, and issuers of Qualified Health Plans, as applicable, who are certified by CMS who assist applicants/enrollees;
6. CMS contractors engaged to perform a function for the Marketplace; and
7. Anyone else as required by law or allowed under the Privacy Act System of Records Notice associated with this collection (CMS Health Insurance Exchanges System (HIX), CMS System No. 09-70-0560, as amended, 78 Federal Register, 8538, March 6, 2013, and 78 Federal Register, 32256, May 29, 2013).

This statement provides the notice required by the Privacy Act of 1974 (5 U.S.C. § 552a(e)(4)). You can learn more about how we handle your information at **HealthCare.gov/privacy**.