Health Insurance Marketplace

10/2014

Form Approved
OMB No. 0938-1190

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

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 their federal income tax return called the "shared responsibility payment."
- Some people are exempt from making this payment. This application is for one category of exemption, for members of a health care sharing ministry. 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 and/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.**
- You can also ask the Internal Revenue Service (IRS) for this exemption when you file your federal income tax return.
- Use this application only if you're requesting an exemption for months of membership in a health care sharing ministry for the current year. If you want to request this exemption for a calendar year after that year ends, you'll need to claim it on your federal income tax return.
- You can use one single application to ask for this exemption for more than one person in your tax household.

What you need to apply

- The name and address of the health care sharing ministry of which you are a member.
- 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.

Get help with this application

- **Online:** HealthCare.gov/exemptions.
- **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.

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**.

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.)

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. If the person **doesn't want an exemption**, just answer questions 1-7 of Step 2.

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

Person 1 must be the person who files a 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 since 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. If yes**, answer all the questions below. ◯ **NO. If no,** skip to question 10.

8. **Tell us about the health care sharing ministry you're a member of. Complete all sections.**

Full name of health care sharing ministry

Address

City | State | ZIP code | County, parish, or township

9. Tell us about time periods when you were a member in good standing — that is, periods when you met all membership requirements, including making any financial contributions required to remain a member.

	Member from	Member to
Date range 1 (mm/yyyy)	___ / ____	___ / ____
Date range 2 (mm/yyyy)	___ / ____	___ / ____
Date range 3 (mm/yyyy)	___ / ____	___ / ____

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

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

11. **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 2

Make a copy of this page 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. If yes**, answer all the questions below. ◯ **NO. If no,** skip to question 11.

9. **Tell us about the health care sharing ministry PERSON 2 is a member of. Complete all sections.**

Full name of health care sharing ministry

Address

City | State | ZIP code | County, parish, or township

10. Tell us about time periods when PERSON 2 was a member in good standing — that is, periods when PERSON 2 met all membership requirements, including making any financial contributions required to remain a member.

	Member from	Member to
Date range 1 (mm/yyyy)	___ / ___	___ / ___
Date range 2 (mm/yyyy)	___ / ___	___ / ___
Date range 3 (mm/yyyy)	___ / ___	___ / ___

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

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

12. **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 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 intentionally provide false or untrue information.
- I know that I must tell the Health Insurance Marketplace within 30 days if anything changes (and is different than) what I wrote on this application. I can visit HealthCare.gov or call **1-800-318-2596** to report any changes. I understand that a change in my information could affect my eligibility as well as 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 hhs.gov/ocr/office/file.

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 4: Mail completed application

Mail your signed application 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 C

Form Approved
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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)
☐☐ / ☐☐ / ☐☐☐☐