pennie® connecting Pennsylvanians to health coverage®

Application for Health Coverage & Financial Assistance

Apply faster online at enroll.pennie.com

Use this application to see what coverage you qualify for

- Affordable private health insurance plans that offer comprehensive coverage to help you stay well.
- A tax credit that can immediately help pay your premiums for health coverage.
- Free or low-cost coverage from Medicaid (Medical Assistance) or the Children's Health Insurance Program (CHIP).
- Certain income levels may qualify for free or low-cost programs.

Who can use this application?

- Use this application for anyone in your household.
- Apply even if you, your spouse or your child have health coverage. You may be eligible for free or lower-cost coverage.
- Households that include eligible immigrants can apply. You can apply for your child even if you aren't eligible for coverage.
- If someone is helping you fill out this application, you may need to complete the attached appendix.

What you may need to apply

- Name, address, birth date, and Social Security Number (or document number if you're an eligible immigrant)) for everyone in the household.
- Employer and income information for everyone in the household (for example, from pay stubs, W-2 forms, or wage and tax statements).
- Policy numbers for any current health insurance.
- Information about any job-related health insurance available to your household.

Why do we ask for this information?

We ask about income and other information to let you know what coverage you qualify for and if you can get any help paying for it.
We'll keep all the information you provide private and secure, as required by law. To view the Privacy Policy, visit pennie.com/policies.

What happens next?

Send your complete, signed application to:

Pennie
PO BOX 2008
Birmingham, AL 35203

If you don't have all the information we ask for, sign and submit your application anyway. We'll follow up with you within 1–2 weeks and you may receive a call from Pennie if we need more information. You'll get an eligibility determination letter in the mail after your application is processed. Filling out this application doesn't mean you have to buy health coverage.

Get help with this application

- **Online:** pennie.com
- **Phone:** Call Pennie Customer Service at 1-844-844-8040. TTY 711.
- **In person**: There are Pennie-certified Assisters in your area who can help. Visit pennie.com, or call Pennie Customer Service at 1-844-844-8040 for more information.
- **En Español:** Llame a nuestro centro de ayuda gratis al 1-844-844-8040.
- **Other languages:** If you need help in a language other than English, call 1-844-844-8040 and tell the customer service representative the language you need. We'll get you help at no cost to you.

You have the right to get the information in this product in an alternate format. You also have the right to file a complaint if you feel you've been discriminated against. Visit www.cms.gov/about-cms/agency-Information/aboutwebsite/cmsnondiscriminationnotice.html, or call the Pennie Customer Service Center at 1-844-844-8040 for more information. TTY 711

Please visit pennie.com/policies for information about our Privacy Policy and Non-Discrimination Policy.

Privacy of Your Information
The privacy of your information is our top priority. We will keep your information private as required by federal and state law. Your answers on this form will only be used to determine eligibility for health coverage. We will verify your answers using the information in our electronic databases and the databases of federal and state agencies. If the information does not match, we may ask you to send us additional documentation. We will not ask any questions about your medical history. If you have questions about a request for information or suspect that the request is not from us, please contact our call center.

Important:
As part of the application process, we may need to retrieve your information from the Social Security Administration, the Department of Homeland Security, the Internal Revenue Service, a consumer reporting agency, and/or other services available through the Federal Data Services Hub. We need this information to check your ability to enroll in coverage. We may also re-verify your information at a later time to make sure your information is up to date. If we re-verify your information, we will notify you if we find something has changed. To learn more, see the ***Notice of Privacy Practices.*** *Visit* ***agency.pennie.com/policies***

Primary Contact Name

First Name | Middle Name | Last Name | Suffix

Date of Birth (MM/DD/YYYY) / /

Primary Contact Home Address

Address 1

Address 2

City | County | State | ZIP Code

Primary Contact Mailing Address

☐ *Check if same as Primary Contact Home Address*

Address 1

Address 2

City | County | State | ZIP Code

Primary Contact Information

Email Address

☐ *Send me important alerts to this email address.*

Mobile Phone Number – – | Home Phone Number – –

☐ *By selecting this box, I consent to receiving calls or texts messages, initiated by electronic means, including an automatic telephone dialing system by, or on behalf of, Pennie to the phone number provided. Carrier charges may apply.*
Pennie's privacy policy can be found at ***pennie.com/privacy.***

Preferred method of communication:

☐ *Go Paperless (specify email)*

☐ *Postal Mail*

With Paperless option, notifications will always be delivered to your Secure Mailbox and you would get a text message or email informing you of the availability of the Notice. With Postal Mail option, apart from Secure Mailbox we also deliver a paper/hard copy of the Notice to your mailing address.

How would you like to receive your 1095-A form?

☐ *Go Paperless (specify email)*

☐ *Postal Mail*

Your 1095-A form is an important document that you need to fill out IRS Form 8962, which you are required to submit as part of your federal income tax return.

Preferred Language for Communications

Preferred Spoken Language ☐ *English* ☐ *Spanish*

Preferred Written Language ☐ *English* ☐ *Spanish*

The primary applicant is the individual who is the primary person applying for insurance. The primary applicant should answer all of questions on pages 3-5 about themselves first. Use subsequent pages to answer the questions for other household members.

Primary Applicant Information

In this section, we will ask for more detailed information on the primary applicant. Following this section, we will ask for more detailed information about everyone in your household.

Primary Applicant

First Name | Middle Name | Last Name | Suffix

Date of Birth (MM/DD/YYYY)   /   /

Sex assigned at birth

Is this person seeking coverage? ☐ *Yes* ☐ *No*

Is the primary applicant married? ☐ *Yes* ☐ *No*

Social Security Number

You must provide the applicant's Social Security Number (SSN) if they have one. If the applicant does not have a Social Security Number, please check the box below or visit www.ssa.gov/ssnumber to apply.
If an SSN exists but is not provided now, the applicant will be required to provide SSN documentation at a later time. Failure to provide the SSN could result in a loss of coverage. Providing a Social Security Number now can help verify your eligibility to enroll in health coverage.

☐ *Check if applicant does not have a Social Security Number.*

Is the name you provided the same on this person's Social Security card? ☐ *No*

If no, please enter the name as shown on the Social Security card.

Is the applicant a U.S. citizen or U.S. national? ☐ *Yes* ☐ *No*

Is the applicant a naturalized citizen or derived citizen? ☐ *Yes* ☐ *No*

If the applicant is not a U.S. citizen or national, do you have an eligible immigration status? ☐ *Yes* ☐ *No*

Immigration Document Type | Status Type (Optional)

Write your name as shown on your immigration document.

Alien Registration or I-94 Number | Permanent Resident Card or Foreign Passport Number

SEVIS ID or expiration date (optional) | Other (category code or country of issuance)

Does the applicant also have any of these documents? (Select all that apply)

- ☐ *Certification from U.S. Department of Health and Human Services (HHS)*
- ☐ *Office of Refugee Resettlement (ORR)*
- ☐ *Office of Refugee Resettlement (ORR) Eligibility Letter (if Under 18)*
- ☐ *Cuban/Haitian Entrant*
- ☐ *Resident of American Samoa*
- ☐ *Battered spouse, child or parent under Violence Against Women Act*
- ☐ *Document indicating member of federally recognized Indian tribe or American Indian born in Canada*
- ☐ *Document indicating withholding of removal*
- ☐ *None of these*

Has the applicant had primary residence in the U.S. since 1996? ☐ *Yes* ☐ *No*

If no, has the applicant had their current immigration status for the last 5 years? ☐ *Yes* ☐ *No*

Help Paying for Coverage

Do you want to find out if your household can get help paying for health coverage? ☐ *Yes* ☐ *No*

If you indicate your household does not want help paying for coverage, you will not need to provide financial information and can skip the Income Information section. However, your household will not be considered for subsidies that could lower your cost of health insurance. Your household will be applying for full-cost insurance.

Income Information

We ask for current information for everyone in your family and household to make sure you get the most benefits possible. Before you start, please take a moment to gather the information listed below. You may need:

- Pay Stubs
- W-2 Forms
- Information about income

Note: We do not need to know about income from child support, veterans payments or supplemental security income

Following income information is based off which family or household member?

Forms of income (Check all that apply)

☐ *Job*	Amount	Frequency	
	Name of employer	Start Date	End Date
☐ *Pension*	Amount	Frequency	
☐ *Rental or Royalty*	Amount	Frequency	
☐ *Alimony Received*	Amount	Frequency	
☐ *Scholarship*	Amount	Frequency	
☐ *Self-Employment*	Amount	Frequency	
☐ *Social Security Benefits*	Amount	Frequency	
☐ *Farming or Fishing*	Amount	Frequency	
☐ *Investment*	Amount	Frequency	
☐ *Retirement*	Amount	Frequency	
☐ *Capital Gains*	Amount	Frequency	
☐ *Unemployment*	Amount	Frequency	
☐ *Other Income*	Amount	Frequency	

If you selected "Other Income," please specify the income type:

- ☐ *Canceled debts*
- ☐ *Cash support*
- ☐ *Court awards*
- ☐ *Gambling, prizes, or awards*
- ☐ *Jury duty pay*
- ☐ *Other* ____________

Expected Income Information

Based on what you know today, how much do you expect to earn for the whole year? If you don't know, that's OK. Make your best estimate.

Total Yearly Amount

____

Deductions

Telling us about the things that can be deducted on an income tax return could lower the cost of your health insurance.

Does the applicant pay any of these deductions?

- ☐ *Alimony* $ ____________ Frequency ____________
- ☐ *Student loan interest* $ ____________ Frequency ____________
- ☐ *Other deductions:* $ ____________ Frequency ____________

About Your Household

In this section, we will ask for more detailed information about everyone in your household. If more than two applicants are applying in addition to the primary applicant, please print extra copies of one of these sections to include with the completed paper application. The primary applicant should use Pages 3-5 to answer these questions about themselves, and then use subsequent pages to answer the questions for each additional household member.

Include each person in your household, even if the person has health coverage already. The information in this application helps us make sure everyone gets the best coverage they can. The amount of help or type of program you qualify for is based on the number of people in your household and your household income. If you don't include someone, even if they already have health coverage, your eligibility results could be affected.

Household Member

First Name | Middle Name | Last Name | Suffix

Date of Birth (MM/DD/YYYY) ___ / ___ / ___

Sex assigned at birth

Is this person seeking coverage? ☐ *Yes* ☐ *No*

How is this person related to the Primary Applicant?

- ☐ *Brother-in-law or Sister-in-law*
- ☐ *Child (Son or Daughter)*
- ☐ *Court Appointed or Live-in Guardian*
- ☐ *Domestic Partner*
- ☐ *First Cousin*
- ☐ *Former Spouse*
- ☐ *Grandchild (Grandson or Granddaughter)*
- ☐ *Grandparent (Grandfather or Grandmother)*
- ☐ *Mother-in-law or Father-in-law*
- ☐ *Nephew or Niece*
- ☐ *Other Relative*
- ☐ *Parent (Mother or Father)*
- ☐ *Sibling (Brother or Sister)*
- ☐ *Son-in-law or Daughter-in-law*
- ☐ *Spouse*
- ☐ *Stepchild (Stepson or Stepdaughter)*
- ☐ *Stepparent (Stepfather or Stepmother)*
- ☐ *Uncle or Aunt*
- ☐ *Ward*
- ☐ *Unrelated*

Does this person live at an address other than the Primary Applicant's address? ☐ *Yes* ☐ *No*
If yes, provide their address below:

Address 1

Address 2

City | County | State | ZIP Code

Does this person have a mailing address other than the Primary Applicant's mailing address? ☐ *Yes* ☐ *No*
If yes, provide their address below:

Address 1

Address 2

City | County | State | ZIP Code

Social Security Number

You must provide the applicant's Social Security Number (SSN) if they have one. If the applicant does not have a Social Security Number, please check the box below or visit www.ssa.gov/ssnumber to apply. If an SSN exists but is not provided now, the applicant will be required to provide SSN documentation at a later time. Failure to provide the SSN could result in a loss of coverage. Providing a Social Security Number now can help verify your eligibility to enroll in health coverage.

☐ *Check if applicant does not have a Social Security Number.*

Is the name you provided the same on this person's Social Security card? ☐ *Yes* ☐ *No*

If no, please enter the name as shown on the Social Security card.

Is the applicant a U.S. citizen or U.S. national? ☐ *Yes* ☐ *No*

Is the applicant a naturalized or derived citizen? ☐ *Yes* ☐ *No*

If the applicant is not a U.S. citizen or national, do you have an eligible immigration status? ☐ *Yes* ☐ *No*

Immigration Document Type

Status Type (Optional)

Write your name as shown on your immigration document.

Alien Registration or I-94 Number

Permanent Resident Card or Foreign Passport Number

SEVIS ID or expiration date (optional)

Other (category code or country of issuance)

Does the applicant also have any of these documents? (Select all that apply)

- ☐ *Certification from U.S. Department of Health and Human Services (HHS)*
- ☐ *Office of Refugee Resettlement (ORR)*
- ☐ *Office of Refugee Resettlement (ORR) Eligibility Letter (if Under 18)*
- ☐ *Cuban/Haitian Entrant*
- ☐ *Resident of American Samoa*
- ☐ *Battered spouse, child or parent under Violence Against Women Act*
- ☐ *Document indicating member of federally recognized Indian tribe or American Indian born in Canada*
- ☐ *Document indicating withholding of removal*
- ☐ *None of these*

Has the applicant had primary residence in the U.S. since 1996? ☐ *Yes* ☐ *No*

If no, has the applicant had their current immigration status for the last 5 years? ☐ *Yes* ☐ *No*

Income Information

We ask for current information for everyone in your family and household to make sure you get the most benefits possible. Before you start, please take a moment to gather the information listed below. You may need:

- Pay Stubs
- W-2 Forms
- Information about income

Note: We do not need to know about income from child support, veterans payments or supplemental security income

Following income information is based off which family or household member?

Forms of income (Check all that apply)

☐ *Job*	Amount	Frequency	
	Name of employer	Start Date	End Date
☐ *Pension*	Amount	Frequency	
☐ *Rental or Royalty*	Amount	Frequency	
☐ *Alimony Received*	Amount	Frequency	
☐ *Scholarship*	Amount	Frequency	
☐ *Self-Employment*	Amount	Frequency	
☐ *Social Security Benefits*	Amount	Frequency	
☐ *Farming or Fishing*	Amount	Frequency	
☐ *Investment*	Amount	Frequency	
☐ *Retirement*	Amount	Frequency	
☐ *Capital Gains*	Amount	Frequency	
☐ *Unemployment*	Amount	Frequency	
☐ *Other Income*	Amount	Frequency	

If you selected "Other Income," please specify the income type:

☐ *Canceled debts*
☐ *Cash support*
☐ *Court awards*
☐ *Gambling, prizes, or awards*
☐ *Jury duty pay*
☐ *Other*

Expected Income Information

Based on what you know today, how much do you expect to earn for the whole year? If you don't know, that's OK. Make your best estimate.

Total Yearly Amount

Deductions

Telling us about the things that can be deducted on an income tax return could lower the cost of your health insurance.

Does the applicant pay any of these deductions?

☐ *Alimony* $	Frequency
☐ *Student loan interest* $	Frequency
☐ *Other deductions:* $	Frequency

About Your Household

In this section, we will ask for more detailed information about everyone in your household. If more than two applicants are applying in addition to the primary applicant, please print extra copies of one of these sections to include with the completed paper application. The primary applicant should use Pages 3-5 to answer these questions about themselves, and then use subsequent pages to answer the questions for each additional family member.

Household Member

First Name | Middle Name | Last Name | Suffix

Date of Birth (MM/DD/YYYY) / /

Sex assigned at birth

Is this person seeking coverage? ☐ *Yes* ☐ *No*

How is this person related to the Primary Applicant?

- ☐ *Brother-in-law or Sister-in-law*
- ☐ *Child (Son or Daughter)*
- ☐ *Court Appointed or Live-in Guardian*
- ☐ *Domestic Partner*
- ☐ *First Cousin*
- ☐ *Former Spouse*
- ☐ *Grandchild (Grandson or Granddaughter)*
- ☐ *Grandparent (Grandfather or Grandmother)*
- ☐ *Mother-in-law or Father-in-law*
- ☐ *Nephew or Niece*
- ☐ *Other Relative*
- ☐ *Parent (Mother or Father)*
- ☐ *Sibling (Brother or Sister)*
- ☐ *Son-in-law or Daughter-in-law*
- ☐ *Spouse*
- ☐ *Stepchild (Stepson or Stepdaughter)*
- ☐ *Stepparent (Stepfather or Stepmother)*
- ☐ *Uncle or Aunt*
- ☐ *Ward*
- ☐ *Unrelated*

Does this person live at an address other than the Primary Applicant's address? ☐ *Yes* ☐ *No*
If yes, provide their address below:

Address 1

Address 2

City | County | State | ZIP Code

Does this person have a mailing address other than the Primary Applicant's mailing address? ☐ *Yes* ☐ *No*
If yes, provide their address below:

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Address 2

City | County | State | ZIP Code

Social Security Number

You must provide the applicant's Social Security Number (SSN) if they have one. If the applicant does not have a Social Security Number, please check the box below or visit www.ssa.gov/ssnumber to apply. If an SSN exists but is not provided now, the applicant will be required to provide SSN documentation at a later time. Failure to provide the SSN could result in a loss of coverage. Providing a Social Security Number now can help verify your eligibility to enroll in health coverage.

☐ *Check if applicant does not have a Social Security Number.*

Is the name you provided the same on this person's Social Security card? ☐ *Yes* ☐ *No*

If no, please enter the name as shown on the Social Security card.

Is the applicant a U.S. citizen or U.S. national? ☐ *Yes* ☐ *No*

Is the applicant a naturalized or derived citizen? ☐ *Yes* ☐ *No*

If the applicant is not a U.S. citizen or national, do you have an eligible immigration status? ☐ *Yes* ☐ *No*

Immigration Document Type

Status Type (Optional)

Write your name as shown on your immigration document.

Alien Registration or I-94 Number

Permanent Resident Card or Foreign Passport Number

SEVIS ID or expiration date (optional)

Other (category code or country of issuance)

Does the applicant also have any of these documents? (Select all that apply)

☐ *Certification from U.S. Department of Health and Human Services (HHS)*
☐ *Office of Refugee Resettlement (ORR)*
☐ *Office of Refugee Resettlement (ORR) Eligibility Letter (if Under 18)*
☐ *Cuban/Haitian Entrant*
☐ *Resident of American Samoa*
☐ *Battered spouse, child or parent under Violence Against Women Act*
☐ *Document indicating member of federally recognized Indian tribe or American Indian born in Canada*
☐ *Document indicating withholding of removal*
☐ *None of these*

Has the applicant had primary residence in the U.S. since 1996? ☐ *Yes* ☐ *No*

If no, has the applicant had their current immigration status for the last 5 years? ☐ *Yes* ☐ *No*

Income Information

We ask for current information for everyone in your family and household to make sure you get the most benefits possible. Before you start, please take a moment to gather the information listed below. You may need:

- Pay Stubs
- W-2 Forms
- Information about income

Note: We do not need to know about income from child support, veterans payments or supplemental security income

Following income information is based off which family or household member?

Forms of income (Check all that apply)

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☐ *Rental or Royalty*	Amount	Frequency	
☐ *Alimony Received*	Amount	Frequency	
☐ *Scholarship*	Amount	Frequency	
☐ *Self-Employment*	Amount	Frequency	
☐ *Social Security Benefits*	Amount	Frequency	
☐ *Farming or Fishing*	Amount	Frequency	
☐ *Investment*	Amount	Frequency	
☐ *Retirement*	Amount	Frequency	
☐ *Capital Gains*	Amount	Frequency	
☐ *Unemployment*	Amount	Frequency	
☐ *Other Income*	Amount	Frequency	

If you selected "Other Income," please specify the income type:

☐ *Canceled debts*
☐ *Cash support*
☐ *Court awards*
☐ *Gambling, prizes, or awards*
☐ *Jury duty pay*
☐ *Other*

Expected Income Information

Based on what you know today, how much do you expect to earn for the whole year? If you don't know, that's OK. Make your best estimate.

Total Yearly Amount

Deductions

Telling us about the things that can be deducted on an income tax return could lower the cost of your health insurance.

Does the applicant pay any of these deductions?

☐ *Alimony*	$	Frequency
☐ *Student loan interest*	$	Frequency
☐ *Other deductions:*	$	Frequency

Household Information

Military Service

Are any of the members of your household an honorably discharged veteran or active duty member of the military? ☐ Yes ☐ No

If yes, please provide the name of the person:

Tax Information

You don't have to file taxes to apply for coverage, but you will need to file next year if you want to get a premium tax credit to help pay for coverage now.

Who plans to file a federal income tax return?

(If married): Do you plan on filing a joint federal income tax return?

Please indicate which of the tax filers should be considered the primary applicant for this application (if filing joint return, this is the Primary Tax Filer)

Who are the dependents who will be claimed by the tax filer(s) on their income tax return?

American Indian/Alaska Native

Are any of the members of your household American Indian/Alaska Natives? ☐ Yes ☐ No

If yes, please provide the name of the person:

Is the tribe federally recognized? ☐ Yes ☐ No

State | Tribe Name

Is the applicant eligible to get health services from the Indian Health Service, a tribal health program or an urban Indian health program, or through referral from one of these programs? ☐ Yes ☐ No

Has the applicant ever gotten a health service from the Indian Health Service, a tribal health program or urban Indian health program, or through a referral from one of these programs? ☐ Yes ☐ No

Medicaid/CHIP Information

Was anyone on this application found not eligible for Medicaid or Children's Health Insurance Program (CHIP) in the past 90 days? ☐ Yes ☐ No

If yes, please provide the name of the household member(s):

When was the applicant denied Medicaid or CHIP coverage? MM/DD/YYYY

Was the applicant found not eligible for Medicaid or CHIP based on immigration status during the last five years, including the current year? ☐ Yes ☐ No

Has the applicant had a change in their immigration status during the last five years, including the current year? ☐ Yes ☐ No

Has the applicant had a change in their immigration status since they were found not eligible for Medicaid or CHIP? ☐ Yes ☐ No

Pregnancy Information

Are any of the members of your household pregnant or were they pregnant in the last 90 days? ☐ Yes ☐ No

If yes, please provide the name of the person:

Is the person still pregnant? ☐ Yes ☐ No

If yes, how many babies are expected in this pregnancy?

When is the due date for this pregnancy? MM/DD/YYYY

If no, when did the pregnancy end? MM/DD/YYYY

Disability Information

Do any of the members of your household have a physical disability or mental health condition that limits their ability to work, attend school or take care of their daily needs? ☐ Yes ☐ No

(If a person needs help only because they're too young to do these things for themselves, don't include their names)

If yes, please provide the name of the person:

Do any of the members of your household need help with activities of daily living (such as bathing, dressing and using the bathroom), or live in a nursing home or other medical facility? ☐ Yes ☐ No

If yes, please provide the name of the person:

Student Information

Are any of the members of your household full-time students? ☐ Yes ☐ No

If yes, please provide the name of the person:

Foster Information

Were any of the members of your household ever in foster care? ☐ Yes ☐ No

If yes, please provide the name of the person:

In what state(s) was/were this/these applicant(s) in the foster care system?

Was/were this/these applicant(s) getting health care through Pennsylvania (Medicaid)? ☐ Yes ☐ No

How old was/were the applicant(s) when they left the foster care system?

Additional Information

Other Coverage

Are any applicants currently enrolled in health coverage that will extend beyond 60 days from today? ☐ Yes ☐ No

If yes, please provide the name of the person:

If yes, what type of coverage does the applicant have?

- ☐ CHIP
- ☐ COBRA Coverage
- ☐ Medicaid
- ☐ Medicare
- ☐ Peace Corps
- ☐ Retiree Health Benefits
- ☐ TRICARE
- ☐ Veterans Affairs (VA) Health Care Program
- ☐ Other Coverage
  - Insurance Name
  - Policy Number
  - Is this a limited benefit coverage? ☐ Yes ☐ No
- ☐ None of the above

Reconciliation of Advanced Premium Tax Credits

In previous years, have you received advance premium tax credits (APTC) to help reduce your monthly payment for coverage through the heath insurance marketplace, including Pennie? ☐ Yes ☐ No

In the years that you received advance premium tax credits (APTC), did you file a tax return and reconcile any APTC you used? NOTE: To reconcile any APTC received during the previous year, you would have received a 1095-A form from the marketplace and used that to submit Internal Revenue Service (IRS) Form-8962 along with your federal income tax return.

☐ Yes ☐ No ☐ No, because I only received APTC in 2020 when reconciliation was not required.

Employer Coverage Details

Will the applicant be offered health coverage through a job (including another person's job, such as a spouse or someone else within the same tax household)? ☐ Yes ☐ No

Employer Name

Employer Phone Number

Address 1

Address 2

City

State

ZIP Code

What is the premium amount for the lowest-cost plan available to this applicant that meets the minimum value standard?

Total amount

Frequency

State Employee Health Benefit

Is applicant offered the Pennsylvania state employee health benefit plan through a job or a family member's job? ☐ Yes ☐ No

Additional Questions

Would the applicant like help paying for medical bills from the last three months? ☐ *Yes* ☐ *No*

Do any of the children on the application have a parent living outside the home? ☐ *Yes* ☐ *No*

Are any applicants incarcerated (in prison or jail)? ☐ *Yes* ☐ *No*

If yes, please provide the name of the person:

Are any of the incarcerated persons awaiting disposition of their charges? ☐ *Yes* ☐ *No*

If yes, please provide the name of the person:

Parent/Caretaker Information:

Is the Primary Applicant the main person taking care of any of the children named in the About Your Household section? ☐ *Yes* ☐ *No*

Optional Questions

These questions are optional, and you do not need to answer them to apply for health insurance. If you choose to answer them, Pennie will use this information to get a better understanding of the demographics and health needs of Pennsylvanians. This information will also be shared with the Department of Health and Human Services to support a broader understanding of health needs across the U.S. population.

Household Member First and Last Name

Hispanic, Latino, or Spanish origin? ☐ *Yes* ☐ *No*

Race (check all that apply):

- ☐ *American Indian or Alaska Native*
- ☐ *Asian Indian*
- ☐ *Black or African American*
- ☐ *Chinese*
- ☐ *Filipino*
- ☐ *Guamanian or Chamorro*
- ☐ *Japanese*
- ☐ *Korean*
- ☐ *Native Hawaiian*
- ☐ *Other Asian*
- ☐ *Other Pacific Islander*
- ☐ *Samoan*
- ☐ *Vietnamese*
- ☐ *White or Caucasian*
- ☐ *Other*
- ☐ *Prefer not to answer*

Household Member First and Last Name

Hispanic, Latino, or Spanish origin? ☐ *Yes* ☐ *No*

Race (check all that apply):

- ☐ *American Indian or Alaska Native*
- ☐ *Asian Indian*
- ☐ *Black or African American*
- ☐ *Chinese*
- ☐ *Filipino*
- ☐ *Guamanian or Chamorro*
- ☐ *Japanese*
- ☐ *Korean*
- ☐ *Native Hawaiian*
- ☐ *Other Asian*
- ☐ *Other Pacific Islander*
- ☐ *Samoan*
- ☐ *Vietnamese*
- ☐ *White or Caucasian*
- ☐ *Other*
- ☐ *Prefer not to answer*

Household Member First and Last Name

Hispanic, Latino, or Spanish origin? ☐ *Yes* ☐ *No*

Race (check all that apply):

- ☐ *American Indian or Alaska Native*
- ☐ *Asian Indian*
- ☐ *Black or African American*
- ☐ *Chinese*
- ☐ *Filipino*
- ☐ *Guamanian or Chamorro*
- ☐ *Japanese*
- ☐ *Korean*
- ☐ *Native Hawaiian*
- ☐ *Other Asian*
- ☐ *Other Pacific Islander*
- ☐ *Samoan*
- ☐ *Vietnamese*
- ☐ *White or Caucasian*
- ☐ *Other*
- ☐ *Prefer not to answer*

Permissions and Sign

Please review the information below and fill out the boxes provided before signing.

To make it easier to reduce the cost of my health insurance in future years, you can agree to allow Pennie to use computer sources, such as the Internal Revenue Service (IRS), to check my income. You also agree to allow Pennie to use your income data, including information from your tax returns, to determine whether you are eligible to continue to receive financial assistance. If those sources show you are still eligible for continued financial assistance, your insurance coverage and financial assistance will be renewed for another 12 months. You understand Pennie will send you a notice explaining that you have been renewed in coverage and allow you to make any changes necessary. You acknowledge if you elect not to give consent, your insurance will be renewed without financial assistance for the following year. You also acknowledge you can discontinue, change, or otherwise opt out at any time.

Do you agree to allow Pennie to use income data, including information from tax returns, for the next five years?

☐ *Yes, allow Pennie to check my information and use it for:*

☐ *1 year* ☐ *2 years* ☐ *3 years* ☐ *4 years* ☐ *5 years (the maximum number of years allowed)*

☐ I agree that my data may be retrieved and used to validate the information on my application. I have consent from all the people that will be included on this application for their information to be retrieved and used to validate the information on this application.

☐ I understand that if anyone on my application enrolls in an Exchange health plan and is later found to have other qualifying health coverage (including Medicare, Medicaid, or CHIP), Pennie will be required to take action, including, but not limited to automatically ending their Exchange health plan or eliminating their advanced premium tax credits or cost-sharing reductions.

☐ I understand that I have 30 days to notify Pennie of any change of information in this application. I will report any changes within this time period. I understand that changes in my household size, address, income, or other details might affect my or my household's eligibility for specific benefits. I understand and will notify Pennie is my application information changes.

☐ By signing below, I consent to my information being shared with the Pennsylvania Department of Human Services for the purposes of making a Medicaid or Children's Health Insurance Program (CHIP) eligibility determination if my application fits specific criteria to be potentially eligible or if I otherwise request a Medicaid or CHIP determination directly.

☐ By signing below, I am giving the Pennsylvania Department of Human Services, as the Medicaid and Children's Health Insurance Program (CHIP) agency, the right to pursue and get any money from other health insurance, legal settlements, or other third parties should someone on this application enroll in Medicaid or CHIP. I am also giving the Pennsylvania Department of Human Services, as the Medicaid agency, the right to pursue and get medical support from a spouse or parent.

☐ I acknowledge that if a child on this application has a parent living outside of the home, I know I will be asked to cooperate with the agency that collects medical support from an absent parent. If I think that cooperating to collect medical support will harm me or my children, I can tell the agency and I may not have to cooperate.

In addition to your application for health insurance, you may **REGISTER** to vote where you living now or **UPDATE** your voter registration record to reflect an address, name, or party affiliation. If you would like to register to vote or update your current registration, please visit the following link: pennie.com/voterregistration

Please note: Pennie does not directly collect voter registration. Your decision whether to register to vote is **voluntary**. Neither registering nor declining to register to vote will in any way affect the availability or the amount of assistance or services you receive from Pennie.

In addition to your application for health insurance, you may **REGISTER** to be an organ and tissue donor. If you would like to register as an organ and tissue donor, please visit the following link: pennie.com/organdonor

Please note: Pennie does not directly collect organ and tissue donor information. Your decision whether to register is voluntary. Neither registering nor declining to register will in any way affect the availability or the amount of assistance or services you receive from Pennie.

☐ I also attest that the information provided in this application, at the time it was submitted, was true and correct to the best of my knowledge.

☐ By signing this application, I am affirming the accuracy of the information provided and any assertions made herein, under penalty of perjury, pursuant to 28 U.S.C. § 1749 and 18 Pa.C.S. § 4904. I acknowledge that I may be subject to penalties under federal and state law if I intentionally provide false information.

Signature of PRIMARY APPLICANT **Date Signed (mm/dd/yyyy)**

____________________ __ / __ / ____

Appendix: Appoint an Authorized Representative

If someone is helping you complete your application, you can designate that person as your Authorized Representative.

An Authorized Representative is any adult who is sufficiently aware of the household circumstances and is authorized by the household to act on behalf of the household for eligibility purposes. By designating an Authorized Representative, you are giving permission for your authorized representative to:

- Sign the application on your behalf
- Act on your behalf for all matters related to the application and account

Please note: An Authorized Representative is not certified by **Pennie**. This is different than designating an Agent or an Assister who has completed training and is certified by **Pennie**.

If you want to appoint an authorized representative, you must complete and submit this form. **Your authorized representative can be an attorney, but does not have to be.**

Your authorized representative can act on your behalf in all other matters before Pennie **until you rescind this appointment (or it expires). If you ever need to change your authorized representative, including removing your authorized representative, please contact Pennie's customer service center at 1-844-844-8040.**

If you are a legally appointed authorized representative for someone, please submit proof with this application.

Make a copy for your records and mail the completed form to: **Pennie, PO Box 2008, Birmingham, AL 35203**

You may also fax the form to a secure fax line: **1-866-350-8233**. Or, you may email the form to **customermatters@pennie.com.**

Step 1: Enter information for the authorized representative.

By appointing an authorized representative, you are requesting that Pennie send all communications to your representative.

Auth. Rep.'s First Name | Middle Name | Last Name | Suffix

Email Address

Address 1

Address 2

City | County | State | ZIP Code

Daytime Phone Number ___ – ___ – ____ | Work Phone Number ___ – ___ – ____

Organization Name (if applicable) | Organization ID (if applicable)

Step 2: Customer Signature

By signing below, the undersigned hereby declares under penalty of perjury, pursuant to 18 Pa.C.S. § 4909, that the above information in this form is true and correct based on their personal knowledge and that the undersigned hereby allows the person named in Step 1 to serve as their authorized representative. By signing this form, the undersigned hereby empowers their authorized representative to act on their behalf with respect to any part of their application until the authorization is otherwise rescinded or it expires.

By signing this form, the undersigned hereby empowers their authorized representative to act on their behalf as specified above for either:

☐ Up to: ___ / ___ / _____ Date (mm/dd/yyyy)

☐ Until I, the applicant, indicate that the representative is no longer authorized to act on my behalf.

Printed Name (First Name, Middle Name, Last Name, Suffix)

Signature

Date (mm/dd/yyyy)

___ / ___ / _____

Step 3: Authorized Representative Signature (other than brokers, navigators or CACs)[1]

By signing below, the undersigned agrees to serve as the authorized representative for the person named in Step 1. The undersigned agrees to be responsible for fulfilling all responsibilities of an authorized representative. Furthermore, the undersigned agrees to maintain and be legally bound to maintain the confidentiality of any information regarding the applicant or enrollee provided by the exchange in accordance with federal and state law. By signing below, the undersigned hereby declares under penalty of perjury, pursuant to 18 Pa.C.S. § 4909, that the information in this form is true and correct based on their personal knowledge and they agree to the terms outlined herein.

Printed Name (First Name, Middle Name, Last Name, Suffix)

Signature

Date (mm/dd/yyyy)

___ / ___ / _____

[1] *Brokers, navigators and CACs have already executed a Non-Exchange Entity agreement that includes these terms and conditions. As a result, their signature is not required. Brokers, navigators and CACs can sign this form if they chose to do so.*

APPENDIX:

Qualified Life Event / Special Enrollment Period Questions

Qualified Health Plan & APTC Program Eligibility Questions

If you are applying for health coverage outside of an Open Enrollment Period, you will need to report a qualifying life event to be eligible to enroll in coverage using a Special Enrollment Period.

Reporting a Qualifying Life Event

In order to qualify for a Special Enrollment Period, you need to take action promptly after experiencing your life event. If you recently lost your other health coverage, you may have up to 120 days after your coverage end date to enroll in a plan through Pennie. For all other life events, you have up to 60 days from the event date to enroll in a plan through Pennie.

Have you experienced one of the following Qualifying Life Events?

Please mark the checkbox below that best describes your change in circumstance and include the date on which the event occurred:

- ☐ *American Indian/Alaska Native Status*
- ☐ *Adoption*
- ☐ *Birth*
- ☐ *Change to Employer Plan, with Gain in Eligibility for Financial Help*
- ☐ *Error – Due to Assister/Broker*
- ☐ *Error – Due to Exchange*
- ☐ *Error – Plan or benefit display*
- ☐ *Exceptional Circumstances – Individual*
- ☐ *Exceptional Circumstances – Natural Disaster*
- ☐ *Exceptional Circumstances – System Backlog*
- ☐ *Exceptional Circumstances – System Error*
- ☐ *Gain a Court-Ordered Dependent*
- ☐ *Gain Eligible Immigration Status*
- ☐ *Income Reduction, with gain in eligibility newly Eligible for Financial Help*
- ☐ *Loss of Medicaid/Medical Assistance (MA) or CHIP*
- ☐ *Loss of Minimum Essential Coverage (MEC)*
- ☐ *Loss of other Qualifying Coverage*
- ☐ *Marriage*
- ☐ *Newly Eligible for Employer Health Reimbursement Arrangement (HRA)*
- ☐ *New Pennsylvania Resident*
- ☐ *Released from Incarceration*
- ☐ *Survivor of Domestic Abuse or Spousal Abandonment*

Date the event occurred (or will occur):

__ / __ / ____ Date (mm/dd/yyyy)

Which household member(s) experienced the qualifying life event as indicated above?

	First Name	Middle Name	Last Name	Suffix
Primary Applicant				
HH Member # 2				
HH Member # 3				
HH Member # 4				

Additional Household members please include on attached sheet of paper.

Please answer the following questions if you experienced one of the following qualifying life events, as you will need to provide additional information to verify your eligibility for coverage using a Special Enrollment Period:

- Change in Address within Pennsylvania
- Divorce (removing someone from a plan)
- Gaining eligible immigration status
- Income reduction, with gain in eligibility for financial help
- Marriage
- New Pennsylvania Resident
- Newly eligible for employer health reimbursement arrangement (HRA)

Is anyone applying for coverage due to a marriage? ☐ *Yes* ☐ *No*
(Select if you checked the 'marriage' checkbox above)

Which household members are applying for coverage, due to a marriage, as listed above?

	First Name	Middle Name	Last Name	Suffix
Primary Applicant				
	First Name	Middle Name	Last Name	Suffix
HH Member # 2				
	First Name	Middle Name	Last Name	Suffix
HH Member # 3				
	First Name	Middle Name	Last Name	Suffix
HH Member # 4				

Did at least one spouse listed above have qualifying health coverage at any time within the 60 days before the marriage? ☐ *Yes* ☐ *No*

Is anyone applying for coverage based on a permanent move to Pennsylvania from another state, a foreign country, a U.S. territory, or within Pennsylvania? ☐ *Yes* ☐ *No*
(Select if you checked 'New Pennsylvania Resident' above)

Which household member(s) are applying based on a permanent move?

	First Name	Middle Name	Last Name	Suffix
Primary Applicant				
	First Name	Middle Name	Last Name	Suffix
HH Member # 2				
	First Name	Middle Name	Last Name	Suffix
HH Member # 3				
	First Name	Middle Name	Last Name	Suffix
HH Member # 4				

Additional Household members please include on attached sheet of paper.

If moved to Pennsylvania from another state: indicate the city and state you moved from below:

City	State

If moved to Pennsylvania from another country or U.S. territory: indicate the country or territory you moved from below:

Country/U.S. Territory

If moved within Pennsylvania: what's the county and ZIP code of your previous address?

County	Zip Code

Did the above household members have qualifying health coverage at any time in the 60 days before they moved? ☐ *Yes* ☐ *No*

Is anyone in the household applying due to gaining an eligible immigration status? ☐ *Yes* ☐ *No*
(Select if you checked 'Gained an Eligible Immigration Status')

Which household members are applying based on gaining an eligible immigration status?

	First Name	Middle Name	Last Name	Suffix
Primary Applicant				
HH Member # 2				
HH Member # 3				
HH Member # 4				

Additional Household members please include on attached sheet of paper.

Is any household member being removed from coverage due to a divorce? ☐ *Yes* ☐ *No*
(Select if you checked 'Divorce' above)

Which household member(s) is being removed from coverage due to a divorce?

	First Name	Middle Name	Last Name	Suffix
Primary Applicant				
HH Member # 2				
HH Member # 3				
HH Member # 4				

Additional Household members please include on attached sheet of paper.

Is anyone in the household applying due to becoming eligible for financial help due to a reduction in income? ☐ *Yes* ☐ *No*
(Select if you checked 'Income Reduction, newly Eligible for Financial Help' above)

Which household member(s) experienced a reduction in income?

	First Name	Middle Name	Last Name	Suffix
Primary Applicant				
HH Member # 2				
HH Member # 3				
HH Member # 4				

Additional Household members please include on attached sheet of paper.

Is anyone in the household applying due to becoming newly eligible for an employer health reimbursement arrangement (HRA)? ☐ *Yes* ☐ *No*
(Select if you checked 'Newly Eligible for Employer Health Reimbursement Arrangement (HRA)' above)

Which household member(s) are applying based on gaining eligibility for a HRA?

	First Name	Middle Name	Last Name	Suffix
Primary Applicant				
HH Member # 2				
HH Member # 3				
HH Member # 4				

Additional Household members please include on attached sheet of paper.

Qualified Life Event / Special Enrollment Period Documents for Verification

If you are applying for coverage based on a qualifying life event that requires additional verification, please see below for a list of documents you can include with this application to confirm your eligibility for a Special Enrollment Period. (Please submit copies only).

New Pennsylvania Resident

- Proof of Prior Coverage (provide any 1 of the following):
  - Private Insurance
  - Government Health Program (Medical Assistance (Medicaid), CHIP, Medicare, TRICARE, Veterans Affairs, Peace Corps)
  - Employer-sponsored coverage, including COBRA
  - Pay stub showing deduction for health coverage
  - Insurance purchased through another state's Marketplace
  - Student Health Coverage
- Proof of Address (provide any 1 of the following):
  - USPS Change of Address confirmation letter
  - Mortgage document
  - Rental or Lease agreement
  - Documentation of move from outside the U.S. with date of entry
  - Voter registration card with new address
  - Homeowner's or renter's insurance with new address
  - Bills or financial statements with new address
  - Government letter with new address
  - Reference letter from another person confirming your residency as well as their own

Change to Employer Plan, Newly Eligible for Financial Help

- Provide documentation verifying your offer of employer-sponsored insurance, including the cost of the coverage and the effective date of that coverage, and the date of the event.

Divorce

- Divorce Decree

Income Reduction, with Gain in Eligibility for Financial Help

- Proof of Current Income (provide any 1 of the following):
  - Federal or state 1040 tax return
  - W2s and/or 1099s
  - Pay stub
  - Self-employment documentation
  - Social Security Benefits Letter
- Proof of Prior Coverage (provide any 1 of the following):
  - Private Insurance
  - Government Health Program (Medical Assistance (Medicaid), CHIP, Medicare, TRICARE, Veterans Affairs, Peace Corps)
  - Employer-sponsored coverage, including COBRA
  - Pay stub showing deduction for health coverage
  - Insurance purchased through another state's Marketplace
  - Student Health Coverage

Marriage

- Marriage certificate or license
- Marriage affidavit or signed and dated affidavit of support by officiant or official witness
- Religious document showing who got married and marriage date
- Official public record showing who got married and marriage date

Newly eligible for employer health reimbursement arrangement (HRA)

- Provide employer notice verifying your offer of employer-sponsored insurance, including the cost of the coverage, the effective date of that coverage, and the date of the event.