

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

If you do not have a mailing address, you can have your postal notices and other coverage information sent through USPS General Delivery. You can learn more at www.faq.usps.com.

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*

Help Applying for Coverage

Is anyone helping you with this application? *Yes* *No*

I am filling out this application for myself and / or my family

I am being assisted by a Pennie certified professional (broker or assister)

I am being assisted by a friend or family member

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

To add an authorized representative see the additional form in the Appendix A.

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.

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
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Date of Birth (MM/DD/YYYY)		Sex assigned at birth	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Is this person seeking coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Is the primary applicant married? <input type="checkbox"/> Yes <input type="checkbox"/> 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.

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Check if applicant does not have a Social Security Number.
Is the name you provided the same on this person's Social Security card?			<input type="checkbox"/> No
If no, please enter the name as shown on the Social Security card.			
<input type="text"/>			

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)
<input type="text"/>	<input type="text"/>

Write your name as shown on your immigration document.

Alien Registration or I-94 Number	Permanent Resident Card or Foreign Passport Number
<input type="text"/>	<input type="text"/>
SEVIS ID or expiration date (optional)	Other (category code or country of issuance)
<input type="text"/>	<input type="text"/>

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)

<input type="checkbox"/> Job	Amount	Frequency	
	Name of employer	Start Date	End Date
<input type="checkbox"/> Pension	Amount	Frequency	
	Amount	Frequency	
<input type="checkbox"/> Rental or Royalty	Amount	Frequency	
	Amount	Frequency	
<input type="checkbox"/> Alimony Received	Amount	Frequency	
	Amount	Frequency	
<input type="checkbox"/> Scholarship	Amount	Frequency	
	Amount	Frequency	
<input type="checkbox"/> Self-Employment	Amount	Frequency	
	Amount	Frequency	
<input type="checkbox"/> Social Security Benefits	Amount	Frequency	
	Amount	Frequency	
<input type="checkbox"/> Farming or Fishing	Amount	Frequency	
	Amount	Frequency	
<input type="checkbox"/> Investment	Amount	Frequency	
	Amount	Frequency	
<input type="checkbox"/> Retirement	Amount	Frequency	
	Amount	Frequency	
<input type="checkbox"/> Capital Gains	Amount	Frequency	
	Amount	Frequency	
<input type="checkbox"/> Unemployment	Amount	Frequency	
	Amount	Frequency	
<input type="checkbox"/> 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
<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>
Date of Birth (MM/DD/YYYY)		Sex assigned at birth	
<input style="width: 25%;" type="text"/>	<input style="width: 25%;" type="text"/>	<input style="width: 25%;" type="text"/>	<input style="width: 25%;" type="text"/>
Is this person seeking coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No			
How is this person related to the Primary Applicant?			
<input type="checkbox"/> Brother-in-law or Sister-in-law <input type="checkbox"/> Child (Son or Daughter) <input type="checkbox"/> Court Appointed or Live-in Guardian <input type="checkbox"/> Domestic Partner <input type="checkbox"/> First Cousin <input type="checkbox"/> Former Spouse <input type="checkbox"/> Grandchild (Grandson or Granddaughter) <input type="checkbox"/> Grandparent (Grandfather or Grandmother) <input type="checkbox"/> Mother-in-law or Father-in-law <input type="checkbox"/> Nephew or Niece <input type="checkbox"/> Other Relative		<input type="checkbox"/> Parent (Mother or Father) <input type="checkbox"/> Sibling (Brother or Sister) <input type="checkbox"/> Son-in-law or Daughter-in-law <input type="checkbox"/> Spouse <input type="checkbox"/> Stepchild (Stepson or Stepdaughter) <input type="checkbox"/> Stepparent (Stepfather or Stepmother) <input type="checkbox"/> Uncle or Aunt <input type="checkbox"/> Ward <input type="checkbox"/> Unrelated	
Does this person live at an address other than the Primary Applicant's address? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, provide their address below:			
Address 1			
<input style="width: 95%;" type="text"/>			
Address 2			
<input style="width: 95%;" type="text"/>			
City	County	State	ZIP Code
<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>
Does this person have a mailing address other than the Primary Applicant's mailing address? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, provide their address below:			
Address 1			
<input style="width: 95%;" type="text"/>			
Address 2			
<input style="width: 95%;" type="text"/>			
City	County	State	ZIP Code
<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>

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)

<input type="checkbox"/> Job	Amount	Frequency
	Name of employer	Start Date End Date
<input type="checkbox"/> Pension	Amount	Frequency
<input type="checkbox"/> Rental or Royalty	Amount	Frequency
<input type="checkbox"/> Alimony Received	Amount	Frequency
<input type="checkbox"/> Scholarship	Amount	Frequency
<input type="checkbox"/> Self-Employment	Amount	Frequency
<input type="checkbox"/> Social Security Benefits	Amount	Frequency
<input type="checkbox"/> Farming or Fishing	Amount	Frequency
<input type="checkbox"/> Investment	Amount	Frequency
<input type="checkbox"/> Retirement	Amount	Frequency
<input type="checkbox"/> Capital Gains	Amount	Frequency
<input type="checkbox"/> Unemployment	Amount	Frequency
<input type="checkbox"/> 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?

<input type="checkbox"/> Alimony	\$	Frequency
<input type="checkbox"/> Student loan interest	\$	Frequency
<input type="checkbox"/> 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?

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

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.

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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
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- None of these

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<input type="checkbox"/> Rental or Royalty	Amount	Frequency
<input type="checkbox"/> Alimony Received	Amount	Frequency
<input type="checkbox"/> Scholarship	Amount	Frequency
<input type="checkbox"/> Self-Employment	Amount	Frequency
<input type="checkbox"/> Social Security Benefits	Amount	Frequency
<input type="checkbox"/> Farming or Fishing	Amount	Frequency
<input type="checkbox"/> Investment	Amount	Frequency
<input type="checkbox"/> Retirement	Amount	Frequency
<input type="checkbox"/> Capital Gains	Amount	Frequency
<input type="checkbox"/> Unemployment	Amount	Frequency
<input type="checkbox"/> 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?

<input type="checkbox"/> Alimony	\$	Frequency
<input type="checkbox"/> Student loan interest	\$	Frequency
<input type="checkbox"/> 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 health 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.

Health Reimbursement Arrangement Details

Will the applicant be offered a Reimbursement Arrangement (HRA) through their job, or through a family member like a spouse or parent? Yes No

What is the start date of your HRA?

/ /

Employer Name

Employer Phone Number

Address 1

Address 2

City

State

ZIP Code

We may contact the employer for information about health coverage offered. if you don't have contact information, please ask your employer.

Who can we contact about your HRA coverage?

First Name	Middle Name	Last Name	Suffix

Email Address

Mobile Phone Number

 -

Address 1

Address 2

City	State	ZIP Code

Employer Identification Number (EIN)

Is the applicant currently enrolled, or planning to enroll in the HRA available to them? Yes No

What Kind of HRA is being offered?

- Individual Coverage Health Reimbursement Arrangement (ICHRA)
- Qualified Small Employer Health Reimbursement Arrangement (QSEHRA)

If you have an offer of an HRA, it could be an individual coverage HRA (ICHRA) or a qualified small employer HRA (QSEHRA). Refer to the notice from your employer to determine which type of HRA you have. QSEHRAs can only be provided by employers with less than 50 full-time employees and may be called something else in your employer notice. If you do not know which HRA you have been offered, contact your employer.

What is the maximum monthly reimbursement amount for your HRA offer(s)?

When will your HRA coverage being?

 / /

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 if 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 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)

Voter Registration (Optional)

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

Would you like to apply to register to vote here today? Yes No

IF YOU DO NOT CHECK EITHER BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.

To register, you must:

1. Be at least 18 on the day of the next election;
2. Be a citizen of the United States for at least one month PRIOR TO THE NEXT ELECTION;
3. Reside in Pennsylvania and the voting district at least 30 days prior to the next election.

Please note: Pennie does not directly collect voter registration. Your decision whether to register to vote is **voluntary**.

Applying to register or declining to register to vote will not affect the amount of assistance you will be provided by this agency. If you would like help filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private. Please contact the county assistance office if you would like help. If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the Secretary of the Commonwealth, PA Department of State, Harrisburg, PA 17120. (Toll-free telephone number 1-877-VOTESPA.)

Appendix A: 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
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Email Address			
<input type="text"/>			
Address 1			
<input type="text"/>			
Address 2			
<input type="text"/>			
City	County	State	ZIP Code
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Daytime Phone Number	Work Phone Number		
<input type="text"/> - <input type="text"/> - <input type="text"/>	<input type="text"/> - <input type="text"/> - <input type="text"/>		
Organization Name (if applicable)	Organization ID (if applicable)		
<input type="text"/>	<input type="text"/>		

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 B: 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
<i>Primary Applicant</i>				
<i>HH Member # 2</i>				
<i>HH Member # 3</i>				
<i>HH Member # 4</i>				

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
<i>Primary Applicant</i>				
<i>HH Member # 2</i>				
<i>HH Member # 3</i>				
<i>HH Member # 4</i>				

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
<i>Primary Applicant</i>				
<i>HH Member # 2</i>				
<i>HH Member # 3</i>				
<i>HH Member # 4</i>				

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
<input type="text"/>	<input type="text"/>

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

Country/U.S. Territory
<input type="text"/>

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

County	Zip Code
<input type="text"/>	<input type="text"/>

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	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
HH Member # 2	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
HH Member # 3	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
HH Member # 4	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

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	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
HH Member # 2	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
HH Member # 3	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
HH Member # 4	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

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
<i>Primary Applicant</i>				
	First Name	Middle Name	Last Name	Suffix
<i>HH Member # 2</i>				
	First Name	Middle Name	Last Name	Suffix
<i>HH Member # 3</i>				
	First Name	Middle Name	Last Name	Suffix
<i>HH Member # 4</i>				

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
<i>Primary Applicant</i>				
	First Name	Middle Name	Last Name	Suffix
<i>HH Member # 2</i>				
	First Name	Middle Name	Last Name	Suffix
<i>HH Member # 3</i>				
	First Name	Middle Name	Last Name	Suffix
<i>HH Member # 4</i>				

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.