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

- Your Social Security Number (or document number if you're an eligible immigrant).
- 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 may be 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.

Primary Contact Name

First Name | Middle Name | Last Name | Suffix

Date of Birth

/ /

Primary Contact Home Address

Address 1

Address 2

City | State | ZIP Code

Primary Contact Mailing Address

☐ *Check if same as Primary Contact Home Address*

Address 1

Address 2

City | State | ZIP Code

Primary Contact Information

Email Address

Mobile Phone Number – –

Home Phone Number – –

Work Phone Number – – x

☐ *By checking this box, I consent to receiving phone calls and text messages. I understand that data rates and fees from my telephone provider may apply.*

Your phone number helps us keep your account secure. Your phone number may be used to deliver a secure code to verify your identity in certain special circumstances. Please provide a number where you can be reached if we need additional information or if we need to contact you about your enrollment.

Preferred method of communication:

☐ *Go Paperless (specify email)*

☐ *Postal Mail*

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

☐ *Go Paperless (specify email)*

☐ *Postal Mail*

Preferred Language for Communications

Preferred Spoken Language ☐ *English* ☐ *Spanish* ☐ *Other:*

Preferred Written Language ☐ *English* ☐ *Spanish* ☐ *Other:*

Preferred Method of Communication ☐ *English* ☐ *Spanish* ☐ *Other:*

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 family 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 ___ / ___ / ___

Sex

Social Security Number

Please provide the applicant's Social Security Number (SSN) if they have one. If no SSN is provided, the applicant will be required to provide additional documentation at the end of the application, and may risk losing eligibility for coverage. Providing a SSN can help verify your eligibility to enroll in coverage. If the applicant does not have a SSN, please visit www.ssa.gov/ssnumber to apply. If this person does not have a Social Security Number, please leave this blank and see the section below to provide further information.

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.

If no Social Security Number is available, please select from the following explanations:

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

Is the applicant a naturalized 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)*
- ☐ *Certificate from the Office of Refugee Resettlement*
- ☐ *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*

Help Paying for Coverage

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

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

Income Information

Please complete income information for each individual applying. 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

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	
☐ *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

Is any of your income from these sources?

- ☐ *Per capita payments from the tribe that come from natural resources, usage rights, leases or royalties.*
- ☐ *Payments from natural resources, farming, ranching, fishing, leases or royalties from land designated as Indian land by the Department of the Interior (including reservations and former reservations).*
- ☐ *Money from selling things that have cultural significance.*

Expected Income Information

Based on what you know today, how much do you think you will make in 2021? 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* $
- ☐ *Student loan interest* $
- ☐ *Other deductions:* $

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.

Family Member

First Name | Middle Name | Last Name | Suffix

Date of Birth ___ / ___ / ___

Sex

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*
- ☐ *Grandparent*
- ☐ *Mother-in-law or Father-in-law*
- ☐ *Nephew or Niece*
- ☐ *Parent (Mother or Father)*
- ☐ *Sibling (Brother or Sister)*
- ☐ *Son-in-law or Daughter-in-law*
- ☐ *Spouse*
- ☐ *Stepchild*
- ☐ *Stepparent*
- ☐ *Uncle or Aunt*
- ☐ *Ward*
- ☐ *Unrelated*

Does this person live at an address other than the Primary Applicant's address? ☐ *Yes* ☐ *No*

If no, provide their address below:

Address 1

Address 2

City | State | ZIP Code

Social Security Number

Please provide the applicant's Social Security Number (SSN) if they have one. If no SSN is provided, the applicant will be required to provide additional documentation at the end of the application, and may risk losing eligibility for coverage. Providing a SSN can help verify your eligibility to enroll in coverage. If the applicant does not have a SSN, please visit www.ssa.gov/ssnumber to apply. If this person does not have a Social Security Number, please leave this blank and see the section below to provide further information.

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.

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

Is the applicant a naturalized 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

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

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- ☐ *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*

Help Paying for Coverage

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

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☐ *Unemployment*	Amount	Frequency
☐ *Other Income*	Amount	Frequency

Is any of your income from these sources?

☐ *Per capita payments from the tribe that come from natural resources, usage rights, leases or royalties.*
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Does the applicant pay any of these deductions?

☐ *Alimony* $

☐ *Student loan interest* $

☐ *Other deductions:* $

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

Who plans to file a federal income tax return for 2020?

(If married): Do you plan on filing a joint federal income tax return for 2020?

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:

State

Tribe Name

Is the tribe federally recognized? ☐ *Yes* ☐ *No*

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 person:

When was the applicant denied Medicaid or CHIP coverage?

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 60 days? ☐ *Yes* ☐ *No*

If yes, please provide the name of the person:

How many babies are expected in this pregnancy?

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 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 Medicaid? ☐ *Yes* ☐ *No*

How old was/were the applicant(s) when he/she/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?

**Don't check the Medicaid box if one of these applies to your coverage: 1) Your coverage pays for only limited benefits, such as family planning services, emergency services, outpatient hospital services or treatment of tuberculosis. 2) Your Medicaid coverage doesn't pay for inpatient hospital services.*

☐ *CHIP*
☐ *COBRA Coverage*
☐ *Medicaid **
☐ *Medicare*
☐ *Peace Corps*
☐ *Retiree Health Benefits*
☐ *TRICARE*
☐ *Veterans Affairs (VA) Health Care Program*
☐ *Marketplace Coverage*
☐ *Other Coverage*

Insurance Name (Optional)

Policy Number (Optional)

Is this a limited benefit coverage? ☐ *Yes* ☐ *No*

Reconciliation of Advanced Premium Tax Credits

For every year that you got a premium tax credit, did you file a tax return and reconcile any premium tax credit that you used?

NOTE: Check Yes only if ALL of these apply to you:

- *You used advance premium tax credits in one or more past years to lower your costs of Marketplace coverage.*
- *You filed a federal income tax return each of these years.*
- *The tax filer(s) submitted IRS Form 8962 with the tax return.*

☐ *Yes* ☐ *No*

Employer Coverage Details

Will the applicant be offered health coverage through a job (including another person's job, such as a spouse or parent)? ☐ *Yes* ☐ *No*

Employer Name

Employer Phone Number

Tell us about coverage offers that apply to them.

Is the employee currently eligible for coverage offered by this employer, or will the employee become eligible in the next three months? If yes, please list the cost to the applicant for the offered employer-sponsored insurance.

☐ *Yes:* ☐ *No*

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

Additional Questions

Would the applicant like help paying for medical bills from the last three months? ☐ *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:

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.

Hispanic/Latino Ethnicity ☐ *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*

Marital Status

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

Who is the applicant's spouse?

- ☐ *Someone already on the application*
- ☐ *Someone else who isn't applying for health coverage*

Parent/Caretaker Information

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

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

If you have experienced a change in circumstance, such as adding a dependent or losing health coverage within the last 60 days, or in some cases, if you will experience such an event within the next 60 days, you may be eligible to enroll in coverage using a Special Enrollment Period.

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:

- ☐ *2021 COVID-19 Enrollment Period*
- ☐ *American Indian/Alaska Native Status*
- ☐ *Adoption*
- ☐ *Birth*
- ☐ *Change in Address within Pennsylvania*
- ☐ *Death of Dependent*
- ☐ *Death of Subscriber*
- ☐ *Divorce*
- ☐ *Error – Plan or benefit display*
- ☐ *Error – Health plan violation*
- ☐ *Error – Due to Exchange*
- ☐ *Error – Due to Assister/Broker*
- ☐ *Exceptional Circumstances – Individual*
- ☐ *Exceptional Circumstances – System Error*
- ☐ *Gain a Court-Ordered Dependent*
- ☐ *Gain Eligible Immigration Status*
- ☐ *Income Reduction, newly Eligible for Financial Help*
- ☐ *Loss of Minimum Essential Coverage*
- ☐ *Loss of other Qualifying Coverage*
- ☐ *Marriage*
- ☐ *New Pennsylvania Resident*
- ☐ *Newly Eligible for Employer Health Reimbursement Arrangement (HRA)*
- ☐ *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
Primary Applicant			
	First Name	Middle Name	Last Name
HH Member # 2			
	First Name	Middle Name	Last Name
HH Member # 3			
	First Name	Middle Name	Last Name
HH Member # 4			

Additional Household members please include on attached sheet of paper.

Please list all household members for whom you are seeking coverage.

	First Name	Middle Name	Last Name
Primary Applicant			
	First Name	Middle Name	Last Name
HH Member # 2			
	First Name	Middle Name	Last Name
HH Member # 3			
	First Name	Middle Name	Last Name
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
Primary Applicant			
	First Name	Middle Name	Last Name
HH Member # 2			
	First Name	Middle Name	Last Name
HH Member # 3			
	First Name	Middle Name	Last Name
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 'Change of Address within Pennsylvania' or 'New Pennsylvania Resident' above)

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

	First Name	Middle Name	Last Name
Primary Applicant			
HH Member # 2			
HH Member # 3			
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
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
Primary Applicant			
	First Name	Middle Name	Last Name
HH Member # 2			
	First Name	Middle Name	Last Name
HH Member # 3			
	First Name	Middle Name	Last Name
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
Primary Applicant			
	First Name	Middle Name	Last Name
HH Member # 2			
	First Name	Middle Name	Last Name
HH Member # 3			
	First Name	Middle Name	Last Name
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 a 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
Primary Applicant			
	First Name	Middle Name	Last Name
HH Member # 2			
	First Name	Middle Name	Last Name
HH Member # 3			
	First Name	Middle Name	Last Name
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).

Change of Address within Pennsylvania/New Pennsylvania Resident

- Copy of deed and record of most recent mortgage payment (if mortgage is paid in full, provide a copy of property tax bill from the most recent year)
- Copy of lease and record of most recent rent payment
- Mortgage showing primary residence address
- Nursery school or daycare records (if school is private, additional documentation may be requested)
- Current utility bill or work order dated within the past 60 days
- Statement from a homeless shelter
- School records (if school is private, additional documentation may be requested)
- Section 8 agreement
- Homeowner's insurance declaration page
- Proof of enrollment of custodial dependent in public school

Change to Employer Plan, Newly Eligible for Financial Help

- Completed Employer Coverage Tool (PDF) and a cover letter signed by the employer
- "Letter or other documentation from an employer or other documentation with this information:
  - Statement that the employer doesn't currently offer you (or your family member) coverage
  - Statement that the employer doesn't provide coverage that is qualifying health coverage
  - Statement showing the cost of your share of the premium for the lowest-cost self-only plan that meets the minimum value standard (factoring in wellness incentives), if offered
- Health insurance letter that contains confirmation of health coverage and expiration dates for coverage received outside of the Marketplace

Divorce

- Divorce Decree

Income Reduction, newly Eligible for Financial Help

- Paycheck stubs showing employee information, pay date or pay period, and gross amount of pay, for the 4 weeks prior to the date listed on your notice.
- 1040 federal or state tax return from the previous year if representative of attested income.
- Wages and tax statement (W-2 and/or 1099, including 1099 MISC, 1099G, 1099R, 1099SSA, 1099DIV, 1099SS, 1099INT) showing first/last name, income amount, year, and employer name (if applicable).
- A signed earning statement from your employer showing first/last name, company contact information and gross pay information, signed by the employer and dated.

NOTE: If you are seasonally employed, any of the proofs above should include information about the duration of your employment.

- Self-Employment ledger documentation showing first/last name, company name, and income amount. If you're submitting a self-employment ledger, include the dates covered by the ledger, and the net income from profit/loss (can be a Schedule C, the most recent quarterly or year-to-date profit and loss statement, or a self-employment ledger).
- 1040 SE with Schedule C, F, or SE (for self-employment income)
- 1065 Schedule K1 with Schedule E
- Tax return
- Bookkeeping records
- Receipts for all allowable expenses
- Signed time sheets and receipt of payroll, if you have employees
- Most recent quarterly or year-to-date profit and loss statement
- Award letter/certificate dated within the last year
- Annual benefit statement
- Correspondence from the Social Security Administration with your award status (denied, award amount, still pending)
- Monthly benefits statement from the PA Department of Labor
- Copy of Direct Payment Card with statement
- Letter from the PA Department of Labor with reason for denial
- Filed tax return if representative of attested rental income
- Agricultural income certificate
- Alimony received: court order stating alimony amount or signed statement from individual providing alimony with amount and frequency.
- Annuity statement
- Bank or investment fund statement
- Cost of living adjustment letter and other benefit verification notices
- Farm Income (See acceptable proof of "Self-Employment Income" listed above)
- Foreign-Earned Income (See acceptable proof of "Income from a Job" listed above)
- Gambling Income: Form W-2G

- Interests and dividends income statement
- Letter, deposit, or other proof of deferred compensation payments
- Letter, deposit, or other proof of travel/business reimbursement pay
- Loan statement showing loan proceeds
- Military Leave and Earnings statement
- Pay stub indicating sick pay
- Pay stub indicating substitute/assistant pay
- Pay stub indicating vacation pay
- Prizes, settlements, and awards, including court-ordered awards letter
- Proof of bonus/incentive payments
- Proof of gifts and contributions
- Proof of inheritances in cash or property
- Proof of residuals
- Proof of severance pay
- Proof of strike pay and other benefits from unions
- Rental, real estate, royalties, partnerships, S-Corps, trusts: rent checks or rental payment receipts, current lease, signed letter from tenant with monthly rental amount, royalty checks, or financial record of payment from trusts
- Royalty income statement or 1099-MISC
- Sales receipts or other proof of money received from the sale, exchange, or replacement of things you own
- Statement of pension distribution from any government or private source
- Worker's compensation letter

Marriage

- Marriage certificate.
- Marriage license.
- Official public record of marriage.
- Marriage affidavit or affidavit of support that's signed and dated by the person who officiated the marriage or the official witness of the marriage.
- Religious document.

Newly eligible for employer health reimbursement arrangement (HRA)

- Notice from your employer showing when your individual coverage HRA or QSEHRA can begin

Please print in capital letters using black or dark blue ink only.

Permissions and Sign

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

To make it easier to determine your eligibility for help paying for coverage in future years, you can agree to allow Pennie to use updated income data, including information from tax returns. Pennie will send a notice and let you make any changes. Pennie will check to make sure you're still eligible, and may have to ask you to confirm that your income still qualifies. You can 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 use income data, including information from tax returns, for next five years.*
- ☐ *No, don't use my tax data to renew my eligibility for help paying for health coverage (selecting this option may impact your ability to get help paying for coverage at renewal).*

If you selected no, eligibility for Advanced Premium Tax Credits or Cost Sharing Reductions may be affected. How far into the future do you allow us to access your tax data?

- ☐ *1 year*
- ☐ *2 years*
- ☐ *3 years*
- ☐ *4 years*
- ☐ *5 years*

If you would prefer we not use any tax data, you acknowledge that this will make you ineligible for Advanced Premium Tax Credits or Cost Sharing Reductions to help lower the cost of your coverage.

By signing below, I understand that if anyone on my application enrolls in a Marketplace 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 Marketplace health plan or eliminating their advanced premium tax credits or cost-sharing reductions.

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 my name in the box 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.

By signing below, 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. 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 my name in the box below, I am signing this application and 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

You have the right to choose an authorized representative to help you. This is a trusted person who has your permission to talk about your application with Pennie, see your information, and act for you on matters related to your application, including receiving information about you and signing documents on your behalf. 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.**

Please Note: Your authorized representative will be able to sign your application as if they were you, submit updates and respond to eligibility redeterminations for you, as well as receive copies of your notices and other communications from Pennie. In addition, 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 customer who is appointing a representative.

First Name | Middle Name | Last Name | Suffix

Date of Birth (/ /)

Email Address

Mailing Address

Apartment or Suite Number

City

State

ZIP Code

Pennie Account # (if you have one)

Step 2: 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

Date of Birth (/ /)

Email Address

Mailing Address

Apartment or Suite Number

City

State

ZIP Code

Daytime Phone Number (– –)

Organization Name (if applicable)

Title (if applicable)

Step 3: 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 2 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)

Signature

Date (mm/dd/yyyy)
/ /

Step 4: 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 his or her personal knowledge and they agree to the terms outlined herein.

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

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.*