access health CT

Connecticut's Health Insurance Marketplace

AH-1500-E00001

APPLICATION FOR EXEMPTION FROM THE INDIVIDUAL RESPONSIBILITY REQUIREMENT

The Patient Protection and Affordable Care Act (ACA) added §5000A to the Internal Revenue Code (IRC) of 1986. Under §5000A, individuals meeting one of the following criteria may be exempt from the penalty imposed for failing to maintain minimum essential coverage, and can apply for an exemption through Access Health CT.

A. Religious Conscience	An individual who provides evidence that he is or she is a member of a federally-recognized religious sect or division, as described in section 1402(g)(1) of the IRC of 1986, which has been in existence at all times since 12/31/1950. Applicant must be adherent to the teachings of such a religious sect or division. Eligibility for an exemption under this heading is governed by Chapter 45, Section § 155.605(c) of the United States Code of Federal Regulations (Code).
B. Membership in a Health Care Sharing Ministry	An individual who is a member of a federally-recognized health care sharing ministry as defined in section 501(c)(3) of the IRC and Chapter 45, Section § 155.605(d) of the Code. Members of the health care sharing ministry must share a common set of beliefs, share medical expenses among members, and be allowed to retain membership even after they develop a medical condition. The ministry must have been in existence since 12/31/1999 and must conduct an annual audit by an independent certified public accounting firm.
C. Incarcerated Individuals	An individual who is incarcerated, not including those who are pending the disposition of charges. Eligibility is governed by Chapter 45, Section § 155.605(e) of the Code.
D. Membership in a recognized Indian Tribe	An individual is an exempt individual for a month that includes a day on which the individual is a member of a federally-recognized Indian tribe or is an Alaskan Native shareholder. Eligibility is governed by Chapter 45, Section § 155.605(f) of the Code.
E. Hardship (General)	An individual suffering a hardship with respect to the capability to obtain coverage under a qualified health plan. Hardships include domestic circumstances (such as a bankruptcy, divorce, or utility shut-off), or other involuntary event that provents or significantly limits the ability of the applicant to obtain and/or maintain and/or use health insurance coverage. Eligibility is governed by Chapter 45, Section § 155.605(g)(1) of the Code.
F. Affordability based on Projected MAGI Income	An individual who is unable to afford health insurance coverage, in accord with Chapter 45, Section § 155.605(g)(2) of the Code, whose projected household Modified Adjusted Gross Income for the period the exemption is sought exceedes the applicable percentage. If request is for a previous year, applicant must claim through tax filing (IRS Form 8965).

To apply for an exemption, please complete Steps 1 through 4 below.

An individual over age 30 wanting to purchase catastrophic coverage must receive a hardship (E) or affordability (F) exemption. Individuals age 30 and younger do not need an exemption to purchase this type of coverage.

While most exemptions must be requested through and granted by an Exchange, there are several other categories of exemptions, In addition to the categories of exemptions above, that tax filers can apply for through the federal income tax filing with the IRS. To claim, a tax filer must complete and submit IRS Form 8965. Information for applying for an individual exemption through the IRS can be found at www.irs.gov.

Note: Exemptions under categories E and F, above, may not be claimed through the tax filing process and must be granted by an Exchange.

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Step 1 Tell us about yourself

1. Name *(first middle last suffix)*

2. **Home** address (If you do not have a Home address, please provide at least the City and State where you are seeking an exemption from healthcare coverage)		3. Apartment or Suite Number
4. City	5. State	6. ZIP code
8. **Mailing** address (If different from home address)		9. Apartment or Suite Number
10. City	11. State	12. ZIP code

14. Preferred phone number ☐Home ☐Work ☐ Cell

15. Other phone number ☐Home ☐Work ☐ Cell

16. Email address	17. Preferred spoken or written language (if not English)

18. Date of birth *(mm/dd/yyyy)*

If under 21 years old, parent or guardian's name: _____

19. Sex
☐ Male ☐ Female

20. Social Security Number (SSN)
__ __ __ – __ __ – __ __ __ __

21. Will you be claimed as a dependent on someone's tax return? ☐ Yes ☐ No

If yes, name of the tax filer: _____

Social Security Number of the tax filer: __ __ __ – __ __ – __ __ __ __

22. Have you completed the Access Health CT application for health coverage? ☐ Yes ☐ No

If yes, list your Application ID (located in the upper right corner of your Eligibility Decision for Health Care Coverage notice):

_____

Step 2 Tell us about your exemption requirements

1. For what duration (dates) are you requesting your individual exemption last?

From *(month/year)*: _____ to: *(month/year)*: _____

2. What was/will be your household's Modified Adjusted Gross Income for the period during which you are requesting an individual exemption?

_____
household Modified Adjusted Gross Income

frequency (circle one)

a. Annually
b. Monthly
c. Weekly
d. Bi-Weekly (every 2 weeks)

NEED HELP WITH YOUR APPLICATION? Email us at **ExemptionsAndAppeals.AHCT@ct.gov** or call us at **1-860-757-6841**.

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Step 2 Tell us about your exemption requirements (continued)

- *See the cover page for the descriptions of the different types of exemptions.*
- *You may apply for more than 1 exemption category. Please include supporting documentation with your application.*

1. Check the exemptions you are applying for:

☐ Religious Conscience

If checked, name of recognized religious organization: _____

☐ Member of a Health Care Sharing Ministry

If checked, name of recognized healthcare sharing ministry: _____

☐ Incarceration

☐ Member of a federally recognized Indian Tribe

If checked, name of federally recognized Indian tribe: _____

☐ Hardship

If checked, please describe in detail and include any supporting documentation. See Appendix B (Page 5) for different types of hardship and the supporting documentation that you will need to submit with this application:

_____

_____

_____

_____

_____

(Attach additional paper if necessary)

☐ Affordability based on Projected Income

To apply for this exemption, you must complete the Access Health CT application for coverage and provide the determination notice or a copy of the online eligibility determination page with your exemption documents.

Step 3 Read and sign this application

- *Sign this application. The person who filled out step 1 should sign this application. If you are an authorized representative, you may sign here as long as you have provided the information required in Appendix A.*

I am signing this application under penalty of perjury. I have provided true answers to all the questions on this form to the best of my knowledge.

Signature of applicant or authorized representative: **Date *(mm/dd/yyyy):***

Step 4 Mail completed application to:

Access Health CT
PO BOX # 670
Manchester, CT 06045-0670

Please allow 90 days for Access Health CT to respond. If you have not received a response after 90 days, please call Access Health CT at 860-757-6841

For information on how Access Health CT collects and uses your personal information, refer to our Privacy Policy at www.accesshealthct.com

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Appendix A

Assistance with completing this application

► *You can choose an authorized representative to assist in completing the application (certified application counselors, in-person assisters, navigators and brokers please see below).*

You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative." If you ever need to change your authorized representative, contact Access Health CT at 1-855-805-4325. If you are a legally appointed representative for someone on this application, submit proof with the application.

► *If you have an authorized representative now, or would like to add one, please answer these questions.*

Select the type of representative:

☐ Court Appointed Representative and Power of Attorney

☐ Responsible Adult

1. Name of authorized representative *(first middle last suffix)*:

2. Address		3. Apartment or suite number
4. City	5. State	6. ZIP code
7. Phone number		
8. Email		

9. Would you like to receive copies of notifications? ☐ Yes ☐ No ***if yes***, preferred language: _____

10. Organization name	11. ID number (if applicable)

By signing, you allow this person to sign your application, get official information about this application, and act for you on all future matters with this agency.

12.Your signature	13. Date *(mm/dd/yyyy)*

For certified application assisters, counselors, navigators, and brokers only.

► *Complete this section if you are a certified application counselor, navigator, agent, or broker filling out this application for somebody else.*

1. Application start date *(mm/dd/yyyy)*

2. Name *(first middle last suffix)*

3. Organization name	4. ID number (if applicable)

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Appendix B

Types of Hardship and Documentation Requirements

*For **use when seeking an exemption under section E (on page 1)***

- *Include the following supporting documents with your* exemption *application submission.*

#	Type	Submit this documentation with your application
1	You were homeless.	None.
2	You were evicted in the past 6 months or were facing eviction or foreclosure.	Copy of eviction or foreclosure notice.
3	You received a shut-off notice from a utility company.	Copy of shut-off notice from a utility company.
4	You recently experienced domestic violence.	None.
5	You recently experienced the death of a close family member.	Copy of death certificate, copy of death notice from newspaper, or copy of other official notice of death.
6	You experienced a fire, flood, or other natural human-caused disaster that caused substantial damage to your property.	Copy of police or fire report, insurance claim, or other document from government agency or private entity documenting event.
7	You filed for bankruptcy in the last 6 months.	Copy of bankruptcy filing.
8	You had medical expenses you couldn't pay in the last 24 months.	Copies of medical bills.
9	You experienced unexpected increases in necessary expenses due to caring for an ill, disabled, or aging family member.	Copies of receipts related to care.
10	You expect to claim a child as a tax dependent who's been denied coverage in Medicaid and CHIP, and another person is required by court order to give medical support to the child.	Copy of medical support order AND copies of eligibility notices for Medicaid and CHIP showing that the child has been denied coverage.
11	As a result of an eligibility appeals decision, you're eligible either for: 1) enrollment in a qualified health plan (QHP) through the Marketplace; 2) lower costs on your monthly premiums; or 3) cost-sharing reductions for a time period when you weren't enrolled in a QHP through the Marketplace.	Copy of notice of appeals decision.
12	Other hardship in obtaining, maintaining, or using health insurance coverage.	Please submit supporting documentation.

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