Application for Health Coverage and Help Paying Costs

Apply faster online at **GetCoveredIllinois.gov**.

Use this application to see what coverage you qualify for	• Get Covered Illinois plans that offer comprehensive coverage to help you stay well. • A tax credit that can immediately help lower your premiums for health coverage and possible reduced cost sharing. • Free or low-cost coverage through Medicaid or All Kids. Certain income levels may qualify for free or low-cost programs.
Get help with this application	• Use this application to apply for anyone in your household. • Apply even if you, your spouse, or your child already have health coverage. You could 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 Appendix A.
What you may need to apply	• Social Security Numbers (SSNs) (or document numbers for any eligible immigrants who need coverage). • Birthdates and addresses for all applicants. • Employer and income information for everyone in your household (like from pay stubs, W-2 forms, or wage and tax statements). • Information about any 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 our privacy notice, visit **GetCoveredIllinois.gov/Privacy**.
What happens next	Send your complete, signed application to the below address: **Get Covered Illinois** **P.O. Box 804058** **Chicago, IL 60680** 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 get a call from Get Covered Illinois if we need more information. You'll get an eligibility notice by your preferred contact method after your application is processed. If you don't hear from us, contact the Customer Assistance Center. Filling out this application doesn't mean you have to buy health coverage. • **Online**: GetCoveredIllinois.gov • **Phone**: Call our Customer Assistance Center at 1-866-311-1119 (TTY: 711). • **In-person**: There may be brokers or navigators in your area who can help. Visit **GetCoveredIllinois.gov**, or call the Get Covered Illinois Customer Assistance Center at 1-866-311-1119 (TTY: 711) for more information. • **En Español:** Llame a nuestro centro de ayuda gratis al 1-866-311-1119 (TTY: 711). • **Other languages**: If you need help in a language other than English, call 1-866-311-1119 (TTY: 711) 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 information from Get Covered Illinois in an accessible format, like large print or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit **GetCoveredIllinois.gov/non-discrimination-policy** or call the Customer Assistance Center at 1-866-311-1119 (TTY: 711) for more information.

Before we begin

Privacy of your information: Your privacy is our top priority. We will keep your information private as required by federal and state law. Your answers on this application will only be used to determine eligibility for health and dental 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 Customer Assistance Center. To learn more, visit **GetCoveredIllinois.gov/Privacy**.

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.

Who to include on your application

Tell us about all the family members that live with you. If you file taxes, we need to know about everyone on your tax return.

DO include:

- Yourself
- Your spouse
- Your children under 19 that live with you
- Your spouse's children under 19 that live with you
- Your unmarried partner, if you have children together
- Anyone you include on your tax return, even if that person does not live with you
- Anyone else under 19 that you take care of and that lives with you

Include the people listed here, even if they do not need health care coverage.

DO NOT include:

- Your children or your spouse's children 19 or older that you do not expect to claim as tax dependents
- Your unmarried partner, if you have no children together and do not file taxes together
- Your unmarried partner's children, if they are not related to you and you do not expect to claim them as tax dependents
- Other people that live with you but are not your spouse or children and that you do not file taxes with
- Your parents, if you are 19 or older, they do not expect to claim you as a tax dependent, and you do not expect to claim them as tax dependents

These people may file a separate application for health care coverage.

The health coverage and help you qualify for depends on the number of people in your family and their incomes. This information helps us make sure everyone gets the best coverage they can.

Complete Step 2 for each person in your family. Start with yourself; then add other adults and children. If you have more than 2 people in your household, make copies of the step 2 pages for each additional member.

Please print in capital letters using black or dark blue ink only. Fill in the check boxes ☐ like this ■.

STEP 1: Tell us about yourself

We need one adult in the family to be the primary contact for your application.

Primary contact information

Primary contact name	First name	Middle name	Last name	Suffix
Home address *If you don't have a home address, enter the ZIP code and county where you currently reside.*	Address line 1			Address line 2
	City	State	ZIP code	County
Mailing address *Enter only if different from your home address.*	Address line 1			Address line 2
	City	State	ZIP code	County
Phone numbers	Mobile phone number (###) ###-####		Home phone number (###) ###-####	
	☐ Send me important alerts to this phone number. Standard message rates may apply.			
Email address	Email address		Send me important alerts to this e-mail address ◯ Yes ◯ No	
Preferred language	Spoken language:		Written language:	
Communication preferences	Preferred method of communication: ◯ Postal mail ◯ Paperless		How do you want to get your 1095-A tax form? ◯ Postal mail ◯ Paperless	
Help with this application	Is anyone helping you with this application? ◯ I am filling out this application for myself and/or my family ◯ I am being assisted by a certified professional (broker or assister) *(complete Appendix A)* ◯ I am being assisted by a friend or family member *(Complete Appendix A if you would like to appoint them to be your authorized representative)*			
Help paying for coverage	Do you want to find out if you can get help paying for health coverage? ◯ Yes (You will need to provide income information to see what you may qualify for) ◯ No (You will pay full cost for your Get Covered Illinois coverage)			

STEP 2: Tell us about your household

Complete Step 2 for each person in your household. Start with yourself, then add other adults and children. **If you have more than 2 people in your household, you'll need to make a copy of the pages and attach them**. You don't need to provide immigration status or Social Security Numbers (SSNs) for household members who don't need health coverage. We'll keep all the information you provide private and secure, as required by law. We'll use personal information only to check if you're eligible for health coverage.

Person 1 Information

Full name	First name:	Middle name:	Last name:	Suffix:
Additional information	Date of birth: (mm/dd/yyyy)	Are you married? ◯ Yes ◯ No	Are you seeking coverage? ◯ Yes ◯ No	
Household relationships	Write in the names of all the other members of your household and how you are related to them:			
Social security number	Social Security Number:		☐ I do not need coverage, so I am not providing my SSN.	
	Do you have a different name on your social security card? ◉ Yes ◯ No		**If yes**, enter the first and last name shown on your social security card below:	
	We need an SSN if you want health coverage and have an SSN or can get one. We use SSNs to check income and other information to see who's eligible for help paying for health coverage. For more information on getting an SSN, visit https://www.ssa.gov/number-card or call Social Security at 1-800-772-1213. TTY users can call 1-800-325-0778.			
Tax household information *You don't have to file taxes to apply for health coverage, but you must file taxes next year to receive a premium tax credit to help you pay for health coverage now.*	Do you plan to file a federal income tax return NEXT YEAR? ◯ Yes ◯ No			
	If yes, will you file jointly with a spouse? ◯ Yes ◯ No		**If yes**, name of spouse:	
	Will you claim any dependents on your tax return? ◯ Yes ◯ No		**If yes**, list names of dependent(s):	
	Will you be claimed as a dependent on someone's tax return? ◯ Yes ◯ No		**If yes**, name of the filer:	**If yes**, how you are related to the filer?
Pregnancy *We ask this information to check if you may be eligible for Medicaid on basis of current or recent pregnancy.*	Are you currently pregnant? ◯ Yes ◯ No		**If yes,** number of babies expected:	**If yes,** due date (mm/dd/yyyy):
	Were you pregnant in the last 90 days? ◯ Yes ◯ No		**If yes**, when did the pregnancy end? (mm/dd/yyyy)	

Disability	Do you have a physical disability or mental health condition that limits your ability to work, attend school, or take care of your daily needs? ◯ Yes ◉ No		
	Do you need help with activities of daily living (like bathing, dressing, and using the bathroom), or live in a nursing home, or other medical facility? ◯ Yes ◯ No		
U.S. citizenship	Are you a U.S. Citizen or U.S. National? ◯ Yes ◯ No		
	If yes, are you a naturalized or derived citizen? ◯ Yes ◯ No **If yes**, provide your naturalization or citizenship certificate number to the right.	Certificate of Naturalization:	Certificate of Citizenship:
Immigration status	If you aren't a U.S. citizen or U.S. national, do you have eligible immigration status? ◯ Yes ◯ No **If yes**, enter immigration document information below.		
	Name (as shown on your document):	Document type:	Document number:	Status type:
	Status award date:	Alien or I-94 number:	Card or passport number:	SEVIS ID number (optional):
	Other (category code or country of issuance):		Document expiration date: (mm/dd/yyyy)	
	Do you also have any of these documents? *(check 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 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			
	Has your primary residence been in the U.S. since 1996? ◯ Yes ◯ No Have you had your current immigration status for the last 5 years? ◯ Yes ◯ No Are you, or your spouse or parent, an honorably discharged veteran or active-duty member of the U.S. military? ◯ Yes ◯ No			

Parent / Caretaker

Do you live with at least one child under the age of 19, and are you the primary person taking care of this child / these children?

◉ Yes ○ No

If yes, list their names and your relationship to them:

Ethnicity (optional)

Are you of Hispanic or Latino ethnicity?

○ Yes ○ No

If yes, check all that apply:

☐ Mexican, Mexican-American, or Chicano/a
☐ Puerto Rican
☐ Cuban
☐ Other _____

Race (optional)

What is your race? *(check all that apply)*

☐ American Indian or Alaska N ☐ Asian Indian ☐ Black or African American
☐ Chinese ☐ Filipino ☐ Guamanian or Chamorro ☐ Japanese ☐ Korean
☐ Middle Eastern North African ☐ Native Hawaiian ☐ Asian American ☐ Other Pacific Islander
☐ Samoan ☐ Vietnamese ☐ White or Caucasian ☐ Other _____

American Indian / Alaska Native

American Indians and Alaska Natives can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. They also may not have to pay cost sharing and may get special monthly enrollment periods.

Are you American Indian or Alaska Native?

○ Yes ○ No

***If yes**, answer the questions below.*

Are you a member of a federally recognized tribe?

○ Yes ○ No

If yes, enter the **tribe name** and the **state** the tribe is located in:

Are you 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

Have you 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

Current job and income information

What is your employment status?

○ Employed (start with Current job 1)
○ Not Employed (skip to Other income section)
○ Self Employed (skip to Self-employment section)

Current job 1

If your pay stub lists "federal taxable wages" (or "taxable income"), enter that amount. If not, enter your gross income (before taxes are taken out) minus any pre-tax deductions withheld by your employer.

Employer name:

Federal tax ID:

Phone number:

Employer address line 1:

Address line 2:

City:

State:

ZIP code:

Wages/tips before taxes:

$

How often?

○ Hourly ○ Daily ○ Weekly ○ Every 2 weeks
○ Twice a month ○ Monthly ○ Yearly
○ One time only

Average number of hours worked per week:

Current job 2

Skip this section if not applicable. If you have additional jobs, make copies of this page and attach them to your application.

Employer name:		Federal tax ID:	Phone number:
Employer address line 1:			Address line 2:
City:	State:	ZIP code:	
Wages/tips before taxes: $	How often? ◯ ◯Daily ◯Weekly ◯Every 2 weeks ◯Twice a month ◯Monthly ◯Yearly ◯One time only		Average number of hours worked per week:

Self-employment income

Type of work:	Profit or loss? ◯Pr ◯Loss
How much net income (profits once business expenses are paid) will you get or how much will you lose from this self-employment this month? $	Average hours worked per week:

Other income this month

Fill in all that apply, and give the amount and how often you get it. You don't need to tell us about income from child support, veteran's payments, or Supplemental Security Income (SSI). If a payment is one time only, write in the month and year.

Type of income	Amount	How often?
☐Unemployment	$	
☐Pension/Retirement	$	
☐Social Security	$	
☐Net Capital Gains	$	
☐Alimony received *(only for divorces finalized before 1/1/2019)*	$	
☐Net farming or fishing income	$	
☐Net rental or royalty income	$	
☐Scholarship	$	
☐Interest, dividends, or other investment income	$	
☐Other income (write type below)	$	

Tribal income

Complete this section only if you are a member of a federally recognized tribe.

Is any of your income from any of these sources? ◯ Yes ◯ No

- 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 Development of Interior (including reservations and former reservations).
- Money from selling things that have cultural significance.

If yes, amount: $	**If yes**, how often?

Deductions

If you pay for certain things that can be subtracted from gross income on a federal income tax return, telling us about them could lower the cost of your health coverage.

Select all that apply, and provide the amount and how often you pay it.

Note: Don't include child support that you pay, or a cost already considered in your answer to net self-employment.

Type of deduction	Amount	How often?
☐ Alimony paid *(Only for divorces finalized before 01/01/2019.)*	$	
☐ Student Loan Interest	$	
☐ Other (Write in type below)	$	

Estimated annual income

Based on what you know today, how much do you think you will make in the calendar year for which you are seeking coverage?

Amount
$

Year

APTC reconciliation

In previous years, have you received advanced premium tax credits (APTC) to help reduce your monthly payment for coverage through the health insurance marketplace, including Get Covered Illinois?

◯ Yes ◯ No

If yes, in the years that you received advance premium tax credits (APTC), did you file a federal income tax return and reconcile any APTC you used?

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

Medicaid / All Kids denial

Were you found not eligible for Medicaid or All Kids in the past 90 days? *(Select yes only if someone was found not eligible for this coverage by the Illinois Department of Healthcare and Family Services (HFS).*

◯ Yes ◯ No

When were you denied Medicaid or All Kids coverage? (mm/dd/yyyy)

Current health coverage

If you have coverage through your employer, report this in the next "Employer coverage" section.

Are you currently enrolled in health coverage that will extend beyond 60 days from today?

◯ Yes ◯ No

If yes, what type of coverage do you have? *(check all that apply)*

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

***If "Other Coverage"** was selected, answer the questions below.*

Insurance Name	Policy Number	Is this a limited benefit coverage?
		◯ Yes ◯ No

(continued on next page)

Employer coverage

Only tell us about coverage offers that apply to the date you seek to begin coverage.

Will you be offered health coverage through a job (including another person's job, like a spouse or parent?

◯Yes ◯No

***If yes**, answer the remaining questions in this section.*

Employer name:		Employer phone number:	
Employer address line 1:			Address line 2:
City:	State:	ZIP code:	

Does this employer offer a health plan that meets the minimum value standard?

◯Yes ◯No

What is the premium amount for the lowest-cost plan available to the person that meets the minimum value standard? (enter to the right)	Cost: $	How often?

Health Reimbursement Arrangements

Only tell us about offers with a start date between 60 days before today and 60 days after today.

Will you be offered a Health Reimbursement Arrangement (HRA) through your job or another person's job?

◯Yes ◯No

***If yes**, answer the remaining questions in this section.*

Employer name:		Employer phone number:	
Employer address line 1:			Address line 2:
City:	State:	ZIP code:	

What type of HRA is offered? ◯Individual Coverage Health Reimbursement Arrangement (ICHRA) ◯Qualified Small Employer Health Reimbursement Arrangement (QSEHRA)	Are you currently enrolled, or planning to enroll, in this HRA offer? ◯Yes ◯No
What is the maximum reimbursement amount for your HRA offer(s)? **$**	When will HRA coverage begin? (mm/dd/yyyy)

State employee health benefit

Are you offered the Illinois state employee health benefit plan through a job or a family member's job?

◯Yes ◯No

Medical bills

Do you want help paying for medical bills from the last 3 months?

◯Yes ◯No

STEP 2: Person 2

Complete Step 2 for your spouse/partner and children who live with you, and/or anyone on your same federal income tax return if you file one. **If you have more than 2 people in your household, you'll need to make a copy of the pages and attach them**. If you don't file a tax return, remember to still add family members who live with you. You will need to file taxes if you receive tax credits. See page 1 for more information about who to include.

Person 2 Information

Full name	First name:	Middle name:	Last name:	Suffix:
Additional information	Date of birth: (mm/dd/yyyy)	Are you married? ◯ Yes ◯ No	Are you seeking coverage? ◯ Yes ◯ No	
Household relationships	Write in the names of all the other members of your household and how you are related to them:			
Social security number	Social Security Number:		☐ I do not need coverage, so I am not providing my SSN.	
	Do you have a different name on your social security card? ◯ Yes ◯ No		**If yes**, enter the first and last name shown on your social security card below:	
	We need an SSN if you want health coverage and have an SSN or can get one. We use SSNs to check income and other information to see who's eligible for help paying for health coverage. For more information on getting an SSN, visit https://www.ssa.gov/number-card or call Social Security at 1-800-772-1213. TTY users can call 1-800-325-0778.			
Tax household information *You don't have to file taxes to apply for health coverage, but you must file taxes next year to receive a premium tax credit to help you pay for health coverage now.*	Do you plan to file a federal income tax return NEXT YEAR? ◯ Yes ◯ No			
	If yes, will you file jointly with a spouse? ◯ Yes ◯ No		**If yes**, name of spouse:	
	Will you claim any dependents on your tax return? ◯ Yes ◯ No		**If yes**, list names of dependent(s):	
	Will you be claimed as a dependent on someone's tax return? ◯ Yes ◯ No		**If yes**, name of the filer:	**If yes**, how you are related to the filer?
Pregnancy *We ask this information to check if you may be eligible for Medicaid on basis of current or recent pregnancy.*	Are you currently pregnant? ◯ Yes ◯ No		**If yes,** number of babies expected:	**If yes,** due date (mm/dd/yyyy):
	Were you pregnant in the last 90 days? ◯ Yes ◯ No		**If yes**, when did the pregnancy end? (mm/dd/yyyy)	

Disability	Do you have a physical disability or mental health condition that limits your ability to work, attend school, or take care of your daily needs? ◯ Yes ◯ No			
	Do you need help with activities of daily living (like bathing, dressing, and using the bathroom), or live in a nursing home, or other medical facility? ◯ Yes ◯ No			
U.S. citizenship	Are you a U.S. Citizen or U.S. National? ◯ Yes ◯ No			
	If yes, are you a naturalized or derived citizen? ◯ Yes ◯ No **If yes**, provide your naturalization or citizenship certificate number to the right.		Certificate of Naturalization:	Certificate of Citizenship:
Immigration status	If you aren't a U.S. citizen or U.S. national, do you have eligible immigration status? ◯ Yes ◯ No **If yes**, enter immigration document information below.			
	Name (as shown on your document):	Document type:	Document number:	Status type:
	Status award date:	Alien or I-94 number:	Card or passport number:	SEVIS ID number (optional):
	Other (category code or country of issuance):		Document expiration date: (mm/dd/yyyy)	
	Do you also have any of these documents? *(check 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 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			
	Has your primary residence been in the U.S. since 1996? ◯ Yes ◯ No Have you had your current immigration status for the last 5 years? ◯ Yes ◯ No Are you, or your spouse or parent, an honorably discharged veteran or active-duty member of the U.S. military? ◯ Yes ◯ No			

Parent / Caretaker	Do you live with at least one child under the age of 19, and are you the primary person taking care of this child / these children? ◯ Yes ◯ No	**If yes,** list their names and your relationship to them:
Ethnicity (optional)	Are you of Hispanic or Latino ethnicity? ◯ Yes ◯ No	**If yes**, check all that apply: ☐ Mexican, Mexican-American, or Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____
Race (optional)	What is your race? *(check all that apply)* ☐ American Indian or Alaska N ☐ Asian Indian ☐ Black or African American ☐ Chinese ☐ Filipino ☐ Guamanian or Chamorro ☐ Japanese ☐ Korean ☐ Middle Eastern North African ☐ Native Hawaiian ☐ Asian American ☐ Other Pacific Islander ☐ Samoan ☐ Vietnamese ☐ White or Caucasian ☐ Other _____	
American Indian / Alaska Native *American Indians and Alaska Natives can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. They also may not have to pay cost sharing and may get special monthly enrollment periods.*	Are you American Indian or Alaska Native? ◯ Yes ◯ No ***If yes**, answer the questions below.*	
	Are you a member of a federally recognized tribe? ◯ Yes ◯ No	**If yes**, enter the **tribe name** and the **state** the tribe is located in:
	Are you 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	Have you 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
Current job and income information	What is your employment status? ◯ Employed (start with Current job 1) ◯ Not Employed (skip to Other income section) ◯ Self Employed (skip to Self-employment section)	

Current job 1 *If your pay stub lists "federal taxable wages" (or "taxable income"), enter that amount. If not, enter your gross income (before taxes are taken out) minus any pre-tax deductions withheld by your employer.*	Employer name:		Federal tax ID:	Phone number:
	Employer address line 1:			Address line 2:
	City:	State:	ZIP code:	
	Wages/tips before taxes: $	How often? ◯ Hourly ◯ Daily ◯ Weekly ◯ Every 2 weeks ◯ Twice a month ◯ Monthly ◯ Yearly ◯ One time only		Average number of hours worked per week:

Current job 2

Skip this section if not applicable. If you have additional jobs, make copies of this page and attach them to your application.

Employer name:		Federal tax ID:	Phone number:
Employer address line 1:			Address line 2:
City:	State:	ZIP code:	
Wages/tips before taxes: $	How often? ◯ Hourly ◯ Daily ◯ Weekly ◯ Every 2 weeks ◯ Twice a month ◯ Monthly ◯ Yearly ◯ One time only		Average number of hours worked per week:

Self-employment income

Type of work:	Profit or loss? ◯ Profit ◯ Loss
How much net income (profits once business expenses are paid) will you get or how much will you lose from this self-employment this month? $	Average hours worked per week:

Other income this month

Fill in all that apply, and give the amount and how often you get it. You don't need to tell us about income from child support, veteran's payments, or Supplemental Security Income (SSI). If a payment is one time only, write in the month and year.

Type of income	Amount	How often?
☐ Unemployment	$	
☐ Pension/Retirement	$	
☐ Social Security	$	
☐ Net Capital Gains	$	
☐ Alimony received *(only for divorces finalized before 1/1/2019)*	$	
☐ Net farming or fishing income	$	
☐ Net rental or royalty income	$	
☐ Scholarship	$	
☐ Interest, dividends, or other investment income	$	
☐ Other income (write type below)	$	

Tribal income

Complete this section only if you are a member of a federally recognized tribe.

Is any of your income from any of these sources? ◯ Yes ◯ No

- 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 Development of Interior (including reservations and former reservations).
- Money from selling things that have cultural significance.

If yes, amount: $	**If yes**, how often?

Deductions

If you pay for certain things that can be subtracted from gross income on a federal income tax return, telling us about them could lower the cost of your health coverage.

Select all that apply, and provide the amount and how often you pay it.

Note: Don't include child support that you pay, or a cost already considered in your answer to net self-employment.

Type of deduction	Amount	How often?
☐ Alimony paid *(Only for divorces finalized before 01/01/2019.)*	$	
☐ Student Loan Interest	$	
☐ Other (Write in type below)	$	

Estimated annual income

Based on what you know today, how much do you think you will make in the calendar year for which you are seeking coverage?

Amount
$

Year

APTC reconciliation

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 Get Covered Illinois?

◯ Yes ◯ No

If yes, in the years that you received advanced premium tax credits (APTC), did you file a federal income tax return and reconcile any APTC you used?

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

Medicaid / All Kids denial

Were you found not eligible for Medicaid or All Kids in the past 90 days? *(Select yes only if someone was found not eligible for this coverage by the Illinois Department of Healthcare and Family Services (HFS).*

◯ Yes ◯ No

When were you denied Medicaid or All Kids coverage? (mm/dd/yyyy)

Current health coverage

If you have coverage through your employer, report this in the next "Employer coverage" section.

Are you currently enrolled in health coverage that will extend beyond 60 days from today?

◯ Yes ◯ No

If yes, what type of coverage do you have? *(check all that apply)*

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

***If "Other Coverage"** was selected, answer the questions below.*

Insurance Name	Policy Number	Is this a limited benefit coverage?
		◯ Yes ◯ No

(continued on next page)

Employer coverage

Only tell us about coverage offers that apply to the date you seek to begin coverage.

Will you be offered health coverage through a job (including another person's job, like a spouse or parent?

◯ Yes ◯ No

***If yes**, answer the remaining questions in this section.*

Employer name:		Employer phone number:	
Employer address line 1:			Address line 2:
City:	State:	ZIP code:	

Does this employer offer a health plan that meets the minimum value standard?

◯ Yes ◯ No

What is the premium amount for the lowest-cost plan available to the person that meets the minimum value standard? (enter to the right)	Cost: $	How often?

Health Reimbursement Arrangements

Only tell us about offers with a start date between 60 days before today and 60 days after today.

Will you be offered a Health Reimbursement Arrangement (HRA) through your job or another person's job?

◯ Yes ◯ No

***If yes**, answer the remaining questions in this section.*

Employer name:		Employer phone number:	
Employer address line 1:			Address line 2:
City:	State:	ZIP code:	

What type of HRA is offered?

◯ Individual Coverage Health Reimbursement Arrangement (ICHRA)

◯ Qualified Small Employer Health Reimbursement Arrangement (QSEHRA)

Are you currently enrolled, or planning to enroll, in this HRA offer?

◯ Yes ◯ No

What is the maximum reimbursement amount for your HRA offer(s)? **$**	When will HRA coverage begin? (mm/dd/yyyy)

State employee health benefit

Are you offered the Illinois state employee health benefit plan through a job or a family member's job?

◯ Yes ◯ No

Medical bills

Do you want help paying for medical bills from the last 3 months?

◯ Yes ◯ No

STEP 3: Review and Sign

Incarceration	Are any applicants incarcerated (in prison or jail)? ◯ Yes ◯ No	**If yes**, tell us the person's name:
	Are any of the incarcerated persons awaiting disposition of their charges? ◯ Yes ◯ No	**If yes**, tell us the person's name:
Renewal consent	To make it easier to reduce the cost of my health insurance coverage in future years, I agree to allow Get Covered Illinois to use computer sources, such as the Internal Revenue Service (IRS), to check my income. I also agree to allow Get Covered Illinois to use my income data, including information from my tax returns, to determine whether I am eligible to continue to receive financial assistance. If those sources show I am still eligible for continued financial assistance, my insurance coverage and financial assistance will be renewed for another 12 months. I understand Get Covered Illinois will send me a notice explaining that I have been renewed in coverage and allow me to make any changes necessary. I acknowledge if I elect not to give this consent, my insurance will be renewed without financial assistance for the following year. I also acknowledge I can discontinue, change, or otherwise opt out at any time. Yes, allow Get Covered Illinois to check my information and use it for: ◯ 5 years (the maximum number of years allowed) ◯ 4 years ◯ 3 years ◯ 2 years ◯ 1 year ◯ I do not give Get Covered Illinois consent to use my income data at renewal.	

On behalf of myself and all of the people listed on this application I understand, represent and agree as follows:

- By signing below, I agree to have my information used and retrieved from data sources such as 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, so that Get Covered Illinois can check my eligibility to enroll in coverage. I have the consent from all the people included on this application for their information to be retrieved and used from data sources mentioned above.
- By signing below, I understand that if anyone on my application is enrolled in Marketplace coverage and is also found to have other coverage (including Medicare, Medicaid, or All Kids), Get Covered Illinois will end their Marketplace plan coverage. They will get a notice before the Marketplace terminates their coverage in case they need to keep it or make changes. During all the months of overlapping coverage, they're responsible for paying the full cost for the Marketplace plan premium and covered services.
- By signing below, I consent to my information being shared with the Illinois Department of Healthcare and Family Services and the Illinois Department of Human Services for the purposes of making a Medicaid or All Kids eligibility determination if my application fits specific criteria to be potentially eligible or if I otherwise request a Medicaid or All Kids determination directly.
- By signing below, I understand that I have 30 days to notify Get Covered Illinois 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 or other details might affect my or my household's
- By signing below, I consent to my information being shared with the Illinois Department of Healthcare and Family Services and the Illinois Department of Human Services for the purposes of making a Medicaid or All Kids eligibility determination if my application fits specific criteria to be potentially eligible or if I otherwise request a Medicaid or All Kids determination directly.
- By signing below, I am giving the Illinois Department of Healthcare and Family Services, as the Medicaid and All Kids 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 All Kids. I am also giving the Illinois Department of Healthcare and Family Services, as the Medicaid agency, the right to pursue and get medical support from a spouse or parent.

- By signing below, I also understand that to be eligible for coverage through Get Covered Illinois, I must be a resident of the state of Illinois. I affirm that I am a resident of Illinois, or that each person applying for coverage is a resident of Illinois. I acknowledge that residency is a condition of eligibility, and I agree to notify Get Covered Illinois if my or any applicant's residency status changes.
- By signing below, 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 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 720 ILCS 5/32-2. I acknowledge that I may be subject to penalties under federal and state law if I intentionally provide false information.

PERSON 1 (the primary contact) should sign this application. If you're an authorized representative, you may sign here as long as PERSON 1 signed Appendix A. If a certified Broker or Navigator has helped you with this application, you will also need to fill out Appendix A.

Print your full name	Signature	Date (mm/dd/yyyy)

If you're signing this application outside of Open Enrollment, make sure you complete Appendix B ("Questions about life changes")

STEP 4: Provide completed application

Mail your signed application to:
Get Covered Illinois
P.O. Box 804058
Chicago, IL 60680

Fax your signed application to:
(888) 973-8254

If you want to register to vote or update an existing voter registration, visit **https://ova.elections.il.gov/**.

For more information, go to **https://getcovered.illinois.gov/en/voter-registration**.

Appendix A: Help with your application

For certified brokers and navigators only

Complete this section if you're a certified Broker or Navigator filling out this application for somebody else.

Your name	First name	Middle name	Last name	Suffix
Your organization	Organization name		Email address	Phone number
ID numbers	ID number (if applicable)		NPN number (brokers and agents only)	

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 you have authorized to act on behalf of your household on Get Covered Illinois. By designating an Authorized Representative, you are giving this individual permission to:

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

Please note: An Authorized Representative is not certified by Get Covered Illinois. This is different than designating a Broker or an Assister who has completed training and is certified by Get Covered Illinois.

Authorized representative name	First name	Middle name	Last name	Suffix
Authorized representative mailing address	Mailing address line 1			Address line 2
	City	State	ZIP code	County
Phone numbers	Mobile phone number (###) ###-####		Home phone number (###) ###-####	
Email address	Email address			
Organization	Is this person part of an organization helping you apply for health insurance? ◯Yes ◯No		If yes, organization name:	If yes, organization ID:

By signing below, I allow this person to sign my application, get official information about this application, and act for me on all future matters related to this application.

Print your full name	Signature	Date (mm/dd/yyyy)

Appendix B: Questions about life changes

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. If eligible, you can enroll in Medicaid or All Kids any time of the year, even if you didn't experience life changes. Members of federally recognized tribes and Alaska Natives can enroll in coverage through Get Covered Illinois any time of the year.

Loss of employer or other coverage	Did anyone lose employer or other coverage in the last 60 days, or expect to lose employer or other coverage in the next 60 days? ◯ Yes ◯ No	
	Name(s):	Date coverage ended or will end:
Loss of Medicaid or All Kids	Did anyone lose Medicaid or All Kids coverage in the last 90 days, or expect to lose Medicaid or All Kids coverage in the next 60 days? ◯ Yes ◯ No	
	Name(s):	Date coverage ended or will end:
New HRA offer	Did anyone receive a new HRA offer in the last 60 days, or expect to receive a new HRA offer in the next 60 days? ◯ Yes ◯ No	
	Name(s):	Date:
Change in employer sponsored coverage	Did anyone become eligible for financial help due to a change in their employer sponsored coverage in the last 60 days, or expect to become eligible for financial help due to a change in their employer sponsored coverage in the next 60 days? ◯ Yes ◯ No	
	Name(s):	Date:
Newly eligible for financial help	Did anyone become eligible for financial help due to a reduction in income in the last 60 days? ◯ Yes ◯ No	
	Name(s):	Date:
Marriage	Did anyone get married in the last 60 days? ◯ Yes ◯ No	
	Name(s):	Date:
Release from incarceration	Did anyone get released from incarceration (detention or jail) in the last 60 days? ◯ Yes ◯ No	
	Name(s):	Date:
Gain of citizenship or immigration status	Did anyone gain eligible citizenship or immigration status in the last 60 days? ◯ Yes ◯ No	
	Name(s):	Date:

Pregnancy	Has anyone been confirmed as pregnant by a licensed provider in the last 60 days? ◯ Yes ◯ No Name(s): Date:
Birth or adoption	Did anyone gain or become a dependent due to birth or adoption in the last 60 days? ◯ Yes ◯ No Name(s): Date:
Gain of dependent due to child support, foster care, or court order	Did anyone gain or become a dependent due to a child support, foster care, or other court order in the last 60 days? ◯ Yes ◯ No Name(s): Date:
Move to Illinois	Did anyone move to Illinois in the last 60 days? ◯ Yes ◯ No Name(s): Date:
Residential address change making new plans available	Did anyone move to a new address within Illinois that made new Marketplace plans available? ◯ Yes ◯ No Name(s): Date:
Error by marketplace or marketplace partner	Did anyone experience an error by the Marketplace or a Marketplace partner in the last 60 days? ◯ Yes ◯ No Name(s): Date:
Delay in Medicaid denial	Was anyone unable to enroll in Marketplace coverage during an eligible enrollment period due to being assessed as potentially eligible for Medicaid, then being found eligible for a qualified health plan? ◯ Yes ◯ No Name(s): Date:
Domestic violence or spousal abandonment	Did anyone experience domestic violence or spousal abandonment last 60 days? ◯ Yes ◯ No Name(s): Date:
Exceptional circumstances	Did anyone experience exceptional circumstances that prevented their enrollment during an eligible enrollment period? ◯ Yes ◯ No Name(s): Date:

Appendix C: Privacy and non-discrimination summary

Privacy Disclosure: Get Covered Illinois protects the privacy and security of the personally identifiable information (PII) that you provide. Your individual identifying information will not be shared, sold, or transferred to any third party without your prior consent, unless required or otherwise permitted by law. Get Covered Illinois may use data from other federal or state agencies to determine eligibility for the individuals on your application. If you have questions about this data, contact Get Covered Illinois at 1-866-311-1119 or TTY 711. For more information about the privacy and security of your information, visit **GetCoveredIllinois.gov/privacy-notice**.

Nondiscrimination Disclosure: In accordance with Section 1557 of the Patient Protection and Affordable Care Act (42 U.S.C. § 18116) and its implementing regulations at 45 CFR Part 92, as well as the Illinois Human Rights Act (775 ILCS 5/1-101 et seq.), Get Covered Illinois does not exclude, deny benefits to, or otherwise discriminate against any person on the basis of race, color, national origin, disability, sex (including pregnancy, sexual orientation, gender identity, and sex stereotypes), age, religion, ancestry, marital status, genetic information, citizenship status, military status, order of protection status, or military discharge status. If you believe you have been discriminated against for any of these reasons, you can file a complaint with Get Covered Illinois's Section 1557 Coordinator: Section 1557 Coordinator / Illinois Department of Insurance / c/o Get Covered Illinois / 115 South LaSalle Street / 13th Floor / Chicago, Illinois 60603 / gci.compliance@illinois.gov. For more information about Get Covered Illinois's Non-Discrimination Policy and Grievance Procedure, visit **GetCoveredIllinois.gov/non-discrimination-policy**.

Get help in another language

If you, or someone you're helping, has questions about Get Covered Illinois, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-866-311-1119, TTY 711.

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Get Covered Illinois, tiene derecho a obtener ayuda información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-866-311-1119, TTY 711.

Jeśli Ty lub osoba, której pomagasz ,macie pytania odnośnie Get Covered Illinois, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku .Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-866-311-1119, TTY 711.

如果您，或您正在幫助的人，有關於Get Covered Illinois方面的問 題，您有權利免費以您的母語得到幫助和訊息。想要跟一位翻譯員通話，請致電1-866-311-1119, TTY 711。

만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Get Covered Illinois에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-866-311-1119, TTY 711로 전화하십시오.

Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Get Covered Illinois, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-866-311-1119, TTY 711.

إن كان لديك أو لدى شخص تساعده أسئلة بخصوص Get Covered Illinois، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم اتصل بـ1-866-311-1119, TTY 711.

Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Get Covered Illinois, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-866-311-1119, TTY 711.

જો તમને અથવા તમે મદદ કરી રહ્યાં છો તેવા કોઈને Get Covered Illinois. વિશે પ્રશ્નો હોય, તો મદદ અને માહિતી મેળવવા માટે તમારું સ્વાગત છે. મદદ તમારી ભાષામાં કોઈપણ ખર્ચ વિના મેળવી શકાય છે. મુદ્દાઓની ચર્ચા કરવા માટે, [અહીં નંબર દાખલ કરો] પર કૉલ કરો.

اگر آپ کسی کی مدد کر رہے ہیں اور آپ کے بارے میں کوئی سوال ہے Get Covered Illinois، تو آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ مترجم سے بات کریں۔

ếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Get Covered Illinois, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình hoàn toàn miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-866-311-1119, TTY 711.

Se tu o qualcuno che stai aiutando avete domande su Get Covered Illinois, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-866-311-1119, TTY 711.

यदि आपको, या आप जिस व्यजति की सहायिा कर रहे हैं, उन्हें इस विषय Get Covered Illinois के बारे में सिाल हैं, ि◌ो आपको मुफ्ि◌ में अपनी भाषा में सहायिा ि◌था ि◌ानकारी लेने का अधिकार है। 1-866-311-1119, TTY 711 पर फ़ोन करें

Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Get Covered Illinois, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-866-311-1119, TTY 711.

Εάν εσείς ή κάποιος που βοηθάτε έχετε ερωτήσεις γύρω απο το Get Covered Illinois , έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας χωρίς χρέωση.Για να μιλήσετε σε έναν διερμηνέα, καλέστε 1-866-311-1119, TTY 711.

Falls Sie oder jemand, dem Sie helfen, Fragen zum Get Covered Illinois haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-866-311-1119, TTY 711 an.

NEED HELP WITH THIS APPLICATION? Visit **GetCoveredIllinois.gov** or call us at **1-866-311-1119** (TTY: 711). If you need help in a language other than English, tell us the language you need. We will get you help at no cost to you.