



Health Insurance Marketplace

Application for a Hardship Exemption



Use this application to apply for a hardship exemption to enroll in a Catastrophic plan

- **If you're over 30** and want to enroll in a Catastrophic plan, you must apply and get approved for an exemption.
- A hardship is a financial or other situation that prevented you from getting health insurance, like being homeless, filing bankruptcy, or getting a shut-off notice from a utility company. Review the full list of hardship situations on the next page.
- If you don't have a hardship, but can't afford coverage available to you, you can apply for an affordability exemption instead. Visit [HealthCare.gov/exemption-form-instructions](https://www.healthcare.gov/exemption-form-instructions) to get the affordability form for your state.
- Catastrophic health plans have lower monthly premiums and very high deductibles. They may be an affordable way to protect yourself from worst-case scenarios, like getting seriously sick or injured. Visit [HealthCare.gov/choose-a-plan/catastrophic-health-plans](https://www.healthcare.gov/choose-a-plan/catastrophic-health-plans) to learn more before you apply.



Who can use this application?

- **Anyone over 30 who wants to enroll in a Catastrophic plan and has a hardship.**
- If you're under 30, you don't need an exemption to enroll in a Catastrophic plan.



What you may need to apply

Documents or a written explanation of your hardship. Get a list of documents on the next page.



Why do we ask for this information?

We ask for Social Security Numbers and other information to match your exemption information to your coverage application. **We'll keep all the information you provide private and secure, as required by law.** For the Privacy Act Statement, visit [HealthCare.gov/privacy](https://www.healthcare.gov/privacy).



Get help with this application

- **Online:** [HealthCare.gov/exemptions](https://www.healthcare.gov/exemptions).
- **Phone:** Call the Marketplace Call Center at **1-800-318-2596**. TTY users can call **1-855-889-4325**.
- **In-person:** There may be trained assisters in your area who can help. Visit [HealthCare.gov/find-local-help](https://www.healthcare.gov/find-local-help), or call the Marketplace Call Center.
- **En Español:** Llame a nuestro centro de ayuda gratis al **1-800-318-2596**.
- **Other languages:** If you need help in a language other than English, call **1-800-318-2596** 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 your information in an accessible format, like large print, braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against.

Visit [CMS.gov/accessibility-nondiscrimination](https://www.cms.gov/accessibility-nondiscrimination) or call **1-800-318-2596**. TTY users can call **1-855-889-4325**.

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Hardship situations and documents to submit

Type of hardship:	Documents to submit:
1. Homeless: You were homeless.	You don't need to submit any documents or a written explanation.
2. Eviction/foreclosure: You were evicted, facing eviction, or facing foreclosure.	Eviction or foreclosure notice. The document must show that the event happened this year or up to 2 years ago.
3. Shut-off notice: You got a shut-off notice from a utility company.	Shut off notice from an electric, water/sewer, or gas utility company. The notice must show that service has been or will be shut off. The document must show that the shut off happened this year or up to 2 years ago.
4. Domestic violence: You're a victim of domestic violence.	You don't need to submit any documents or a written explanation.
5. Death of family member: A close family member died.	Death certificate, death notice from newspaper, funeral service program, funeral expenses, coroner's report, military notification of death, or other official notice of death. The document must show that the death happened this year or up to 2 years ago.
6. Disaster: You had a fire, flood, or other natural or human-caused disaster that caused substantial damage to your property.	Police or fire report, insurance claim, or other official documents about the disaster. The document must show that the event happened this year or up to 2 years ago.
7. Bankruptcy: You filed for bankruptcy.	Bankruptcy filing from a court or other legal authority. The document must show that the bankruptcy happened this year or up to 2 years ago.
8. Medical expenses: You had medical expenses you couldn't pay.	One or more medical bills. The bill(s) must be for this year or up to 2 years ago.
9. Increase in expenses to care for family member: You had an unexpected increase in necessary expenses due to caring for an ill, disabled, or aging family member.	Receipts for family members' care, like medical bills, home care services, or transportation receipts. The receipts must be from this year or up to 2 years ago.
10. Medical support for child: A child you expected to claim as a tax dependent was denied coverage in Medicaid and the Children's Health Insurance Program (CHIP), and another person is required by court order to provide health coverage to the child.	Court order that covers the time period that you want the exemption for the child, and copy of their Medicaid and CHIP denial letter from your state. This letter must show eligibility decision for this year or up to 2 years ago.
11. Eligibility appeals decision: Your Marketplace appeal decision said you're eligible for 1 of the items below during a time when you didn't have Marketplace coverage: • Enrollment in a Marketplace plan • Lower monthly premiums • Cost-sharing reductions (extra savings)	Appeals notice from the Marketplace or your state-based Marketplace. The appeals notice must be from this year or up to 2 years ago.
12. Ineligible for Medicaid: An adult in your tax household was found ineligible for Medicaid because your state didn't expand eligibility for Medicaid under the Affordable Care Act.	None. This hardship is only available if you were found ineligible this year.
13. Cancellation of individual coverage: You got a notice from a health insurance plan you purchased on the individual market (not job based coverage) saying your policy was cancelled because it didn't meet Affordable Care Act requirements and you considered other plans unaffordable.	This category is no longer available for 2017 and future years.
14. Other hardship: You had another hardship NOT listed that kept you from getting health insurance. It must be a different situation than the others listed in items 1–13.	Include any documents that explain why you're asking for a hardship exemption. Documents or your explanation must show that the hardship happened this year or up to 2 years ago.





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All fields required unless marked optional.

Print in capital letters using black or dark blue ink only.

Fill in the circles (○) like this → ●.

Step 1: Tell us about yourself

Enter the information for the person who files your household's federal income tax return. This is "PERSON 1" for the rest of this application. If you're applying for an exemption for a dependent, the person who claims the dependent on their federal income tax return fills out and signs this application.

Use your legal name.

1. First name	Middle name	Last name	
2. Home address (Leave blank if you don't have one.)			3. Apartment or suite number
4. City	5. State	6. ZIP code	7. County, parish, or township
8. Mailing address ☐ (Select if same as home address)			9. Apartment or suite number
10. City	11. State	12. ZIP code	13. County, parish, or township

We may need to contact you about this application. We won't use your phone number for anything else.

14. Phone number	Best time to call:
() -	☐ Morning ☐ Afternoon ☐ Evening ☐ Weekend
15. Second phone number (optional)	Best time to call:
() -	☐ Morning ☐ Afternoon ☐ Evening ☐ Weekend
16. Do you want to get correspondence from the Marketplace? ☐ Yes ☐ No	
Email address:	
17a. What is your preferred spoken language?	17b. What is your preferred written language?

Optional: Fill in all that apply.

18. If Hispanic/Latino, ethnicity:	☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other
19. Race:	☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Filipino ☐ Japanese ☐ Korean ☐ Asian Indian ☐ Chinese ☐ Vietnamese ☐ Other Asian ☐ Native Hawaiian ☐ Guamanian or Chamorro ☐ Samoan ☐ Other Pacific Islander ☐ Other





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Step 2: Tell us about your tax household and hardship(s) you had

Apply for this exemption based on how you file taxes. If you're 21 or older and a dependent on someone else's tax return, submit your own exemption application.

Include:

- The adult listed as "PERSON 1" in Step 1.
- A spouse, if filing taxes jointly.
- Anyone in your household being claimed as a dependent by PERSON 1.

DON'T include:

- Anyone in your household who files their own taxes. They must fill out a separate exemption application for themselves and include every person they claim on their tax return.
- Anyone who lives with PERSON 1, but isn't (or won't be) listed on their tax return for the year(s) you want this exemption.

Tell us about your tax household

Complete for each person included on your federal income tax return. List the person from Step 1 first. They're PERSON 1 on this application.

★ **We need your Social Security Number (SSN), if you have one.** We use SSNs to correctly match this request to your coverage application. For more information on getting an SSN, visit [SSA.gov](https://ssa.gov), or call Social Security at 1-800-772-1213. TTY users can call 1-800-325-0778.

PERSON 1

1. First name	MI	Last name
2. Relationship to PERSON 1 SELF	3. Date of birth (mm/dd/yyyy) 	4. Social Security Number (SSN)
		5. Sex ☐ Female ☐ Male
6. Do you want an exemption? ☐ YES ☐ NO		

PERSON 2

1. First name	MI	Last name
2. Relationship to PERSON 1 ☐ Spouse ☐ Dependent	3. Date of birth (mm/dd/yyyy) 	4. Social Security Number (SSN)
		5. Sex ☐ Female ☐ Male
6. Does PERSON 2 want an exemption? ☐ YES ☐ NO		

PERSON 3

1. First name	MI	Last name
2. Relationship to PERSON 1 ☐ Spouse ☐ Dependent	3. Date of birth (mm/dd/yyyy) 	4. Social Security Number (SSN)
		5. Sex ☐ Female ☐ Male
6. Does PERSON 3 want an exemption? ☐ YES ☐ NO		



Step 2: Tell us about your tax household and hardship(s) you had (continued)

Tell us about your tax household

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PERSON 4

1. First name	MI	Last name
2. Relationship to PERSON 1 ☐ Spouse ☐ Dependent	3. Date of birth (mm/dd/yyyy) 	4. Social Security Number (SSN)
		5. Sex ☐ Female ☐ Male
6. Does PERSON 4 want an exemption? ☐ YES ☐ NO		

PERSON 5

1. First name	MI	Last name
2. Relationship to PERSON 1 ☐ Spouse ☐ Dependent	3. Date of birth (mm/dd/yyyy) 	4. Social Security Number (SSN)
		5. Sex ☐ Female ☐ Male
6. Does PERSON 5 want an exemption? ☐ YES ☐ NO		

PERSON 6

1. First name	MI	Last name
2. Relationship to PERSON 1 ☐ Spouse ☐ Dependent	3. Date of birth (mm/dd/yyyy) 	4. Social Security Number (SSN)
		5. Sex ☐ Female ☐ Male
6. Does PERSON 6 want an exemption? ☐ YES ☐ NO		





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Step 2: Tell us about your tax household and hardship(s) you had (continued)

Tell us about your hardship

Select the hardship(s) your household had and tell us when it happened.

Use the person numbers from the prior section to tell us who had that hardship.

Type of hardship (Select all that apply)	Who had this hardship?	Year you want exemption (Select one)	Date hardship started and ended (or will end) (mm/dd/yyyy)	Check if ongoing
☐ 1. Homeless	☐ All ☐ Person 1 ☐ Person 4 ☐ Person 2 ☐ Person 5 ☐ Person 3 ☐ Person 6	☐ 2026 ☐ 2027	Date started (must be a date in the past) ____/____/____ Date ended (or will end) ____/____/____	☐ Yes ☐ No
☐ 2. Eviction/foreclosure	☐ All ☐ Person 1 ☐ Person 4 ☐ Person 2 ☐ Person 5 ☐ Person 3 ☐ Person 6	☐ 2026 ☐ 2027	Date started (must be a date in the past) ____/____/____ Date ended (or will end) ____/____/____	☐ Yes ☐ No
☐ 3. Shut-off notice	☐ All ☐ Person 1 ☐ Person 4 ☐ Person 2 ☐ Person 5 ☐ Person 3 ☐ Person 6	☐ 2026 ☐ 2027	Date started (must be a date in the past) ____/____/____ Date ended (or will end) ____/____/____	☐ Yes ☐ No
☐ 4. Domestic violence	☐ All ☐ Person 1 ☐ Person 4 ☐ Person 2 ☐ Person 5 ☐ Person 3 ☐ Person 6	☐ 2026 ☐ 2027	Date started (must be a date in the past) ____/____/____ Date ended (or will end) ____/____/____	☐ Yes ☐ No
☐ 5. Death of family member	☐ All ☐ Person 1 ☐ Person 4 ☐ Person 2 ☐ Person 5 ☐ Person 3 ☐ Person 6	☐ 2026 ☐ 2027	Date started (must be a date in the past) ____/____/____ Date ended (or will end) ____/____/____	☐ Yes ☐ No
☐ 6. Disaster	☐ All ☐ Person 1 ☐ Person 4 ☐ Person 2 ☐ Person 5 ☐ Person 3 ☐ Person 6	☐ 2026 ☐ 2027	Date started (must be a date in the past) ____/____/____ Date ended (or will end) ____/____/____	☐ Yes ☐ No





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Step 2: Tell us about your tax household and hardship(s) you had (continued)

Tell us about your hardship

Type of hardship (Select all that apply)	Who had this hardship?	Year you want exemption (Select one)	Date hardship started and ended (or will end) (mm/dd/yyyy)	Check if ongoing
☐ 7. Bankruptcy	☐ All ☐ Person 1 ☐ Person 4 ☐ Person 2 ☐ Person 5 ☐ Person 3 ☐ Person 6	☐ 2026 ☐ 2027	Date started (must be a date in the past) ____/____/____ Date ended (or will end) ____/____/____	☐ Yes ☐ No
☐ 8. Medical expenses	☐ All ☐ Person 1 ☐ Person 4 ☐ Person 2 ☐ Person 5 ☐ Person 3 ☐ Person 6	☐ 2026 ☐ 2027	Date started (must be a date in the past) ____/____/____ Date ended (or will end) ____/____/____	☐ Yes ☐ No
☐ 9. Increase in expenses to care for family member	☐ All ☐ Person 1 ☐ Person 4 ☐ Person 2 ☐ Person 5 ☐ Person 3 ☐ Person 6	☐ 2026 ☐ 2027	Date started (must be a date in the past) ____/____/____ Date ended (or will end) ____/____/____	☐ Yes ☐ No
☐ 10. Medical support for child	☐ All ☐ Person 1 ☐ Person 4 ☐ Person 2 ☐ Person 5 ☐ Person 3 ☐ Person 6	☐ 2026 ☐ 2027	Date started (must be a date in the past) ____/____/____ Date ended (or will end) ____/____/____	☐ Yes ☐ No
☐ 11. Eligibility appeals decision	☐ All ☐ Person 1 ☐ Person 4 ☐ Person 2 ☐ Person 5 ☐ Person 3 ☐ Person 6	☐ 2026 ☐ 2027	Date started (must be a date in the past) ____/____/____ Date ended (or will end) ____/____/____	☐ Yes ☐ No
☐ 12. Ineligible for Medicaid	☐ All ☐ Person 1 ☐ Person 4 ☐ Person 2 ☐ Person 5 ☐ Person 3 ☐ Person 6	☐ 2026 ☐ 2027	Date started (must be a date in the past) ____/____/____ Date ended (or will end) ____/____/____	☐ Yes ☐ No





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Step 2: Tell us about your tax household and hardship(s) you had (continued)

Tell us about your hardship

Type of hardship (Select all that apply)	Who had this hardship?	Year you want exemption (Select one)	Date hardship started and ended (or will end) (mm/dd/yyyy)	Check if ongoing
☐ 13. Cancellation of individual coverage	☐ All ☐ Person 1 ☐ Person 4 ☐ Person 2 ☐ Person 5 ☐ Person 3 ☐ Person 6	☐ 2026 ☐ 2027	Date started (must be a date in the past) Date ended (or will end) 	☐ Yes ☐ No
☐ 14. Other hardship	☐ All ☐ Person 1 ☐ Person 4 ☐ Person 2 ☐ Person 5 ☐ Person 3 ☐ Person 6	☐ 2026 ☐ 2027	Date started (must be a date in the past) Date ended (or will end) 	☐ Yes ☐ No

If you selected hardship 14, tell us how this hardship prevented you and/or others in your household from getting health coverage. (Limit 700 characters)



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Step 3: Read, print and sign this application

Make sure you complete all required information. We can't process incomplete or unsigned applications or accept digital signatures.

I agree that:

- I'm signing this application under penalty of perjury, which means I've provided true answers to all the questions on this form to the best of my knowledge. I know that I may be subject to penalties under federal law if I intentionally provide false or untrue information.
- I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, or disability. I can file a complaint of discrimination by visiting [HHS.gov/civil-rights/filing-a-complaint](https://www.hhs.gov/civil-rights/filing-a-complaint).

PERSON 1 should sign this application. PERSON 1 must be 18 or older and listed in Step 1. If you're an authorized representative, you may sign here as long as PERSON 1 fills out and signs the "Help with this application" form on the last page of this application.

Print the application and have PERSON 1 sign.

Signature	Date signed (mm/dd/yyyy)

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. This information collection supports a consumer's ability to apply for and receive a certificate of exemption from the requirement to enroll in minimum essential coverage under the Affordable Care Act. We ask about income and other information to let you know what type of exemption you may qualify for. The valid OMB control number for this information collection is 0938-1190. Some of the information we collect is voluntary, but other information is required by provisions within the Affordable Care Act. The information we collect is held private in accordance with regulations at 45 CFR 155.260, Privacy and Security of Personally Identifiable Information. Pursuant to this regulation, we may only use or disclose personally identifiable information to the extent that such information is necessary to carry out legally and regulatorily mandated functions. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. If you have questions or concerns regarding where or how to submit your documents, please contact the Marketplace Call Center at 1-800-318-2596 (TTY: 1-855-889-4325).



Step 4: Mail completed application and documents



Mail your **signed** application and **copies (don't send originals)** of the documents to:

Health Insurance Marketplace
Attn: Exemption Processing
465 Industrial Blvd.
London, KY 40741

What happens next?

We'll call you if we need more information. If we don't reach you by phone, we'll send a letter.

After we process your application, we'll send you a letter with our decision.

- If your request is approved, you'll get an exemption approval number (called an "Exemption Certificate Number (ECN)") for each person approved to enroll in a Catastrophic plan.
 - Your exemption applies only for the period you're approved. You may have to re-apply if you update or start a new Marketplace coverage application.
 - You must log into your Marketplace account and enter your approval number to view and pick a Catastrophic plan that meets your needs.
 - If your state has its own Marketplace, check with them for how to provide your approval number. Some state-based Marketplaces only use part of the number.
- If you or other members of your tax household don't qualify for the exemption, the letter will explain why.
- If you don't hear from us within 30 days, contact the Marketplace at **1-800-318-2596**. TTY users can call **1-855-889-4325**.

What if I think the results of my exemption application are wrong?

You can appeal.

- We must get your appeal request within 90 days of the date on your results notice.
- You can have someone request or participate in your appeal if you want to. That person can be a friend, relative, lawyer, or other individual. Or, you can request and participate in your appeal on your own.
- The outcome of an appeal could change the eligibility of other members of your tax household.

To appeal your exemption application results, visit HealthCare.gov/marketplace-appeals. Or call the Marketplace Call Center at **1-800-318-2596**. TTY users can call **1-855-889-4325**.





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Help with Completing this Application

You can choose an authorized representative.

You can give a trusted person permission to talk about this application with us, access 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.” This person will be the main contact for your application, not you. We’ll send all communications about your application to the person you choose. If you ever need to change or remove your authorized representative, contact the Marketplace. If you’re a legally appointed representative for someone on this application, submit proof with the application.

1. First name of authorized representative	MI	Last name
2. Address		3. Apartment or suite number
4. City	5. State	6. ZIP code
7. Phone number		
() -		
8. Organization name (if applicable)		
9. 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 related to this application. The person who signs this form must be PERSON 1 (18 or older and listed in Step 1).

10. Signature of PERSON 1	11. Date signed (mm/dd/yyyy)

Submit documents to prove the person listed is the legal authorized representative for PERSON 1 in this application. Most people send a copy of one of these:

- Power of Attorney (POA)
- Court order or document showing legal guardianship or conservatorship

For certified application counselors, navigators, agents, and brokers only

Complete this section only if you’re a certified application counselor, navigator, agent, or broker filling out this application for somebody else.

1. Application start date (mm/dd/yyyy)	
2. First name	MI Last name
3. Organization name (if applicable)	
4. ID number (if applicable)	5. Agents/Brokers only: NPN number

