CERTIFICATE OF EXEMPTION TY13 APPLICATION

You do not need to fill out this application if:

1. You are insured in a health insurance plan that meets minimum creditable coverage (MCC) standards for all months in 2013 that you were a Massachusetts resident (see page 5 for information about MCC);
2. Your gap(s) in creditable insurance coverage were each for 3 months or less in 2013
3. Your annual income is under 150% of the Federal Poverty Level (See Table 1 on page 5); or
4. You are claiming a Religious Exemption.

A complete application must be submitted no later than **December 1, 2013**. Applications received after December 1, 2013 and incomplete applications will be dismissed. You will have another opportunity, however, to present your case as part of your tax return. The Connector may revoke a Certificate of Exemption if it determines at a later date that the information contained in this Application is inaccurate.

SECTION I. Clearly Print Your Information

First Name | Middle Initial | Last Name | Date of Birth

Mailing Address | City | State | Zip | SS#

If married, name of Spouse | Spouse Date of Birth | Is Spouse Applying for a Certificate? □ Yes □ No | Spouse SS#

Current Street Address (If different from street address)

Telephone Number | Number of Dependents

Name of Dependent(s)	Age	Relationship	Name of Dependent(s)	Age	Relationship
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1. **Will you have MCC compliant health insurance coverage at *any* point during 2013?**
   □ Yes [*Proceed to Question 1a*] □ No [*Go to Question 2*]

1a. **Please identify the insurer(s) and indicate below which months you will have had at least 15 days of MCC compliant health insurance. If you will have been insured for 14 days or fewer, do not check off the box for that month. If your coverage will not have met MCC, do not check off the box for that month.**

Name of Insurer: _____

You: □January □February □March □April □ May □June □July □August □ September □ October □November □December

Spouse: □January □February □March □April □ May □June □July □August □ September □ October □November □December

Name of Insurer: _____

You: □January □February □March □April □ May □June □July □August □ September □ October □November □December

Spouse: □January □February □March □April □ May □June □July □August □ September □ October □November □December

Any boxes that are not checked off above are considered your "uninsured period." We will consider your application for a Certificate of Exemption for your whole uninsured period.

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2. What is your estimated 2013 household adjusted gross income? (Gross income includes all forms of income, such as salaries, unemployment benefits, bank interest, dividends, or retirement distributions. It is income before any deductions are taken, such as tax withholdings. If you are self-employed, use only your Net Business Income. If you are married, include both spouses' incomes.)

*My estimated 2013 household income is $*_____

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3. In 2013 will health insurance have been available to you through your or your spouse's employer?

□ Yes □ No

3a. What is the cost of the lowest-priced plan available to you through an employer?

*The monthly premium for my family would be $*_____

3b. Does the insurance your employer offers meet Minimum Creditable Coverage standards?

□ Yes □ No

3c. Does your or your spouse's employer offer to pay more than 20% of the cost for a family insurance plan or 33% of the cost for an individual plan? (The employer's Human Resources Department should be able to provide this information.)

□ Yes □ No

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4. During your uninsured period, will you have applied for MassHealth or Commonwealth Care?

□ Yes □ No

4a. During your uninsured period, will you have been a U.S. citizen or an alien legally residing in the United States?

□ Yes □ No

4c. During your uninsured period, will you or your spouse have been collecting unemployment benefits from Massachusetts?

□ Yes □ No

4d. During your uninsured period, will you or your spouse have been a student at a Massachusetts college or university with access to student insurance?

□ Yes □ No

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5. What hardship event did you experience in 2013? Check all that apply, explain in the space on Page 3, and attach documents, dated 2013 to prove your claim. Please send copies only. Originals will not be returned. If you do not send documentation, your request may not be approved. Attach additional pages, if needed.

□ You are homeless, or more than 30 days behind in rent or mortgage payments, or have received a current eviction or foreclosure notice.

□ You have a shut-off notice from your utility company (gas, electric, oil, water, or telephone), or one of your utilities has been shut off, or one or more of your utility companies is refusing to deliver services because you cannot pay.

□ You have a significant, unexpected increase in essential expenses directly resulting from the consequences of

- domestic violence;
- death of your spouse, family member, or partner with primary responsibility for child care where that spouse, family member or partner had shared household expenses with you;
- the sudden responsibility for providing full care for an aging parent or other family member, including a major extended illness of a child that requires a working parent to hire a full-time caretaker for the child;
- a fire, flood, natural disaster, or other unexpected natural or human-caused event causing large damage to you or, your home, or your property or personal possessions.

□ You experienced financial circumstances such that the expense of purchasing health insurance would have caused you to experience a serious deprivation of food, shelter, clothing or other necessities.

□ You purchased health insurance that did not meet Minimum Creditable Coverage standards because that is what your employer offered or because it was close to or substantially met those requirements, and you felt that your circumstances prevented you from buying other insurance that met the requirements.

□ Other factors make insurance unaffordable, such as large family size, inability to obtain government sponsored insurance despite being eligible, or residency outside of Massachusetts during your uninsured period.

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5. (continued) Use the space below to explain your circumstances during 2013. Your explanation helps us make a decision by giving us a complete understanding of your situation. Attach documents to support your statement.

DESIGNATION OF REPRESENTATIVE (if any)

You may, but are not required to, designate someone as your Representative. By designating this Representative, you are authorizing the Connector to share your personal health and financial information with that Representative.

Representative First and Last Name

Representative Telephone Number

Representative Mailing Address, City, State, Zip Code

Representative Relationship

SIGNATURE

Under penalties of perjury, I/we declare that to the best of my/our knowledge and belief this Application and enclosures are true, correct and complete. I/we authorize the release of this Application and supporting documentation to the Connector and contracted entities for the purposed of making a decision on my/our exemption request.

Your Signature

Date

Print Name (First, Last)

Spouse's Signature

Date

Print Name (First, Last)

FEDERAL POVERTY LEVEL GUIDELINES TABLES

Table 1: Income at **150%** of the Federal Poverty Level

Family Size	Annual Income
1	$17,244
2	$23,268
3	$29,304
4	$35,328
5	$41,364
6	$47,388
7	$53,424
8	$59,448
Additional	+ $6,036

- □ If you are married and file a joint tax return, use both spouses' incomes
- □ If you are married and file separate returns, but live in the same household, use both spouses' incomes

MINIMUM CREDITABLE COVERAGE STANDARDS

For Tax Year 2013 a health insurance plan meets Minimum Creditable Coverage standards if it has:

- Coverage for a comprehensive set of services (for example: doctors visits, hospital admissions, day surgery, emergency services, mental health and substance abuse, maternity and newborn care, radiation and chemotherapy, and prescription drug coverage)
- Doctor visits for preventive care, without a deductible
- A cap on annual deductibles of $2,000 for an individual and $4,000 for a family
- All services must be provided to all of those covered (for example, a plan that covers dependents must extend maternity services to them)
- For plans with up-front deductibles or co-insurance on core services, an annual maximum on out-of-pocket spending of no more than $5,000 for an individual and $10,000 for a family
- No caps on total benefits for a particular illness or for a single year
- No policy that covers only a fixed dollar amount per day or stay in the hospital, with the patient responsible for all other charges
- For policies that have a separate prescription drug deductible, it cannot exceed $250 for an individual or $500 for a family
- No cap on prescription drug benefits

If the health insurance plan does not cover one or more of these services, then the plan is not MCC compliant. If you do not know if the health plan provides these services, please contact your human resources department or health benefit department or contact the health insurance carrier directly.

You automatically meet MCC if you are enrolled in:

- Commonwealth Care
- Commonwealth Choice
- MassHealth plan (except MassHealth Limited)
- Medicare Part A or B
- A Student Health Insurance Plan offered in Massachusetts or another state
- U.S. Military health benefits, including TRICARE and U.S. Veterans Administration healthcare programs
- A health arrangement provided by an established religious organization comprised of individuals of sincerely held religious beliefs
- A medical care program of the Indian Health Service or a tribal organization
- Peace Corps, VISTA or AmeriCorps or National Civilian Community Corps coverage