



# Application for Exemption for American Indians and Alaska Natives and Other Individuals who are Eligible to Receive Services from an Indian Health Care Provider



## Use this application to apply for an exemption from the shared responsibility payment

- Every person needs to have health coverage or make a payment on their federal income tax return called the “shared responsibility payment.”
- Some people are exempt from making this payment. This application includes two categories of exemptions for American Indians and Alaska Natives. There are other applications for other categories of exemptions. You may apply for certain other categories of exemptions when you file your federal income tax return.
- You can also ask the Internal Revenue Service (IRS) for these exemptions when you file your federal income tax return instead of completing this application.
- You don’t need to apply for an exemption if you’re not going to file a federal income tax return. If you’re not sure you’ll file a tax return, you may want to apply for an exemption anyway.



## Who can use this application?

- **Use this application if you and/or anyone in your tax household is:**
  - **A member of a federally recognized tribe or Alaska Native Claims Settlement Act (ANCSA) Corporation shareholder.**
  - **An individual who’s eligible for health services through the Indian Health Service, tribes and tribal organizations, or urban Indian organizations.**
- You only need to apply once to get the lifetime exemption, unless your membership or eligibility for services from an Indian health care provider ends.
- Use one application for everyone you will include on your federal income tax return. Any member of your household who files his or her own tax return will need to submit his or her own exemption application.



## What you need to apply

- Each person who wants this exemption needs to provide documents showing tribal membership, Alaska Native corporation shareholder status, or eligibility for services from the Indian Health Service, a tribal health care provider, or an urban Indian health care provider (see page 5).
- Copy both sides of any cards and all pages of the documentation you provide with this application.
- Social Security Numbers (SSNs), if you have them.



## Why do we ask for this information?

We ask for Social Security Numbers and other information to make sure your exemption is counted when you file your federal income tax return. **We’ll keep all the information you give private and secure, as required by law.** To view the Privacy Act Statement, go to [HealthCare.gov](http://HealthCare.gov) or see instructions.



## Get help with this application

- **Online:** [HealthCare.gov/exemptions](http://HealthCare.gov/exemptions).
- **Phone:** Call the Marketplace Call Center at **1-800-318-2596**. TTY users should call **1-855-889-4325**.
- **In person:** There may be counselors in your area who can help. Visit [HealthCare.gov](http://HealthCare.gov), or call the Marketplace Call Center at **1-800-318-2596** for more information.
- **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.





Please print in capital letters using black or dark blue ink only. Fill in the circles (○) like this → ●.

### STEP 1: Tell us about yourself.

(The person who files a federal income tax return in your household should be the contact person for this application. If you're applying for an exemption for a child, we need an adult who claims the child on his or her federal income tax return to fill out this information even if the adult doesn't need the exemption.)

Give your legal name

1. First name	Middle name	Last name	Suffix
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

2. Home address (Leave blank if you don't have one.)	3. Apartment or suite number
<input type="text"/>	<input type="text"/>

4. City	5. State	6. ZIP code	7. County, parish, or township
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

8. Mailing address (if different from home address)	9. Apartment or suite number
<input type="text"/>	<input type="text"/>

10. City	11. State	12. ZIP code	13. County, parish, or township
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

14. Daytime phone number ( <input type="text"/> <input type="text"/> <input type="text"/> ) <input type="text"/> - <input type="text"/>	15. Evening phone number ( <input type="text"/> <input type="text"/> <input type="text"/> ) <input type="text"/> - <input type="text"/>
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Please give us a phone number so the Marketplace can contact you if we need more information to process your application. We won't use your phone number for any other purpose.

16. Do you want to get information by email from the Marketplace? .....  Yes  No

Email address:

17. What's your preferred spoken language? What's your preferred written language?

### STEP 2: Tell us about your tax household.

#### Who do you need to include on this application?

You need to complete Step 2 for every person in your household who is on the same federal income tax return. If the person **doesn't want an exemption**, just answer questions 1-7 of Step 2.

#### For Person 1:

Person 1 must be an adult who files a federal income tax return in your household, even if they don't want an exemption.

#### For Person 2:

Person 2 can be either:

- A spouse who files taxes jointly with Person 1.
- Anyone that Person 1 claims as a dependent on the same tax return.

#### Who not to include:

- A spouse who files taxes separately. Spouses who file separately need to fill out a separate application for themselves and for each person they claim on their tax return.
- Anyone who lives with you but who isn't listed on your tax return. Each person who needs an exemption must be on an application with the person who lists them on a tax return.

#### If you don't plan to file taxes, you don't need to apply for an exemption.

You'll get an eligibility determination letter in the mail after your application is processed. If you get this exemption, we'll give you an Exemption Certificate Number (ECN) with your approval letter. **Keep the letter for your records.** You'll need to put this number on your federal income tax return at the time you file taxes.

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 an exemption.



# STEP 2: PERSON 1

Person 1 must be the person who files a federal income tax return, even if the person doesn't need this exemption.

1. First name	Middle name	Last name	Suffix

2. Relationship to you? <b>SELF</b>	3. Date of birth (mm/dd/yyyy) [ ]/[ ]/[ ]	4. Sex <input type="radio"/> Male <input type="radio"/> Female
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5. Social Security Number (SSN) [ ]-[ ]-[ ]

**If you're requesting an exemption for yourself and you have an SSN, you must provide it. You aren't required to have an SSN to get this exemption. If you're not requesting an exemption for yourself, providing your SSN can be helpful since it can speed up the application process.**  
 We use SSNs to help make sure that if you get an exemption, it's applied correctly on your taxes. If someone wants help getting an SSN, call **1-800-772-1213** or visit [socialsecurity.gov](https://www.socialsecurity.gov). TTY users should call **1-800-325-0778**.

6. **Do you plan to file a federal income tax return?** .....  Yes  No

a. Will you file jointly with a spouse? .....  Yes  No

**If yes**, write name of spouse: \_\_\_\_\_

b. Will you claim any dependents on your tax return? .....  Yes  No

**If yes**, list name(s) of dependents: \_\_\_\_\_

7. Do you want this exemption?  **YES. If yes**, answer all the questions below. **Make sure you provide one of the required documents on page 5.**   
 **NO. If no**, leave the rest of this page blank.

8. Are you a member of a federally recognized tribe or Alaska Native Claims Settlement Act (ANCSA) Corporation shareholder?  
 **YES. If yes**, provide the name of the Indian tribe or Alaska Native corporation below.  
 \_\_\_\_\_  
**If yes**, leave the rest of this page blank.  
 **NO. If no**, go to question 9.

9. If you're not a member of an Indian tribe or ANCSA corporation shareholder, are you eligible to get services through an Indian health care provider?  
 **YES. If yes**, answer questions 10 through 12.  **NO. If no**, leave the rest of this page blank.

10. When did you become eligible to get services for an Indian health care provider (mm/dd/yyyy)? Leave blank if you've been eligible since birth. Tell us the date you first became eligible for services, NOT your date of birth.  
 [ ]/[ ]/[ ]

11. Are you ONLY eligible to get services through an Indian health care provider because you're pregnant with the child of an individual eligible for services from an Indian health care provider?  
 **YES. If yes**, provide the due date (mm/yyyy) of your baby (or babies) below. Then leave the rest of this page blank.  
 [ ]/[ ]  
 **NO.**

12. If your eligibility for services through an Indian health care provider has ended or will end, provide the date (mm/dd/yyyy).  
 [ ]/[ ]/[ ]



# STEP 2: PERSON 2

Make a copy of this page if there are more than 2 people in your household.

Fill out this page for a spouse who files taxes jointly with you and for anyone you claim as a dependent on your federal income tax return.

1. First name	Middle name	Last name	Suffix
<input type="text"/>			

2. Relationship to PERSON 1? <input type="text"/>	3. Date of birth (mm/dd/yyyy) <input type="text"/> / <input type="text"/> / <input type="text"/>	4. Sex <input type="radio"/> Male <input type="radio"/> Female
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5. Social Security Number (SSN)  -  -

**If PERSON 2 is requesting an exemption and has an SSN, he or she must provide it. PERSON 2 isn't required to have an SSN to get this exemption.** We use SSNs to help make sure that if you get an exemption, it's applied correctly on your taxes. If someone wants help getting an SSN, call **1-800-772-1213** or visit [socialsecurity.gov](https://socialsecurity.gov). TTY users should call **1-800-325-0778**.

6. Does PERSON 2 plan to file a federal income tax return?  Yes  No

**If yes**, answer 6a and 6b. **If no**, go to question 7.

a. Will PERSON 2 file jointly with a spouse?  Yes  No

**If yes**, write name of spouse:

b. Will PERSON 2 claim any dependents on his/her tax return?  Yes  No

**If yes**, list name(s) of dependents:

7. Will PERSON 2 be claimed as a dependent on PERSON 1's tax return?  Yes  No

**If yes**, please list the name of the tax filer:

How is PERSON 2 related to the tax filer?

**Note:** If PERSON 2 isn't listed on PERSON 1's tax return as a spouse or as a dependent, PERSON 2 must file a separate application.

8. Does PERSON 2 want this exemption?  **YES. If yes**, answer all the questions below. **Make sure you provide one of the required documents on page 5.**  **NO. If no**, leave the rest of this page blank.

9. Is PERSON 2 a member of a federally recognized tribe or Alaska Native Claims Settlement Act (ANCSA) Corporation shareholder?

**YES. If yes**, provide the name of the Indian tribe or Alaska Native corporation below.

**If yes**, leave the rest of this page blank.

**NO. If no**, go to question 10.

10. If PERSON 2 is not a member of an Indian tribe or ANCSA corporation shareholder, is he/she eligible to get services through an Indian health care provider?

**YES. If yes**, answer questions 11 through 13.  **NO. If no**, leave the rest of this page blank.

11. When did PERSON 2 become eligible to get services for an Indian health care provider (mm/dd/yyyy)? Leave blank if PERSON 2 has been eligible since birth. Tell us the date PERSON 2 first became eligible for services, NOT PERSON 2's date of birth.

/  /

12. Is PERSON 2 ONLY eligible to get services through an Indian health care provider because she is pregnant with the child of an individual eligible for services from an Indian health care provider?

**YES. If yes**, provide the due date (mm/yyyy) of PERSON 2's baby (or babies) below. Then leave the rest of this page blank.

/

**NO.**

13. If PERSON 2's eligibility for services through an Indian health care provider has ended or will end, provide the date (mm/dd/yyyy).

/  /



### STEP 3: Read & sign this application

- 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 I must tell the Health Insurance Marketplace within 30 days if anything changes (and is different than) what I wrote on this application. I can visit [HealthCare.gov](https://www.healthcare.gov) or call **1-800-318-2596** to report any changes. I understand that a change in my information could affect my eligibility as well as eligibility for member(s) of my household.
- I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting [hhs.gov/ocr/office/file](https://www.hhs.gov/ocr/office/file).

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

If you don't agree with the results of your exemption application, you can ask for an appeal. Below is important information to consider when requesting an appeal:


- The Health Insurance Marketplace must receive your appeal request within 90 days of the date of the notice of the application results.
- You may have a relative, friend, legal counsel, or another spokesperson, including an Authorized Representative, help you make an appeal request or participate in your appeal. This is optional.
- 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/](https://www.healthcare.gov/marketplace-appeals/). Or call the Marketplace Call Center at **1-800-318-2596**. TTY users should call **1-855-889-4325**.

**PERSON 1 should sign this application.** If you're an authorized representative, you may sign here as long as PERSON 1 signed Appendix C. The person who signs this application must be the person who files a federal income tax return and is an adult over the age of 18.

Signature	Date signed (mm/dd/yyyy)
→ <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>

### STEP 4: Mail completed application


 Mail your signed application and Include your documentation showing tribal membership or eligibility for services through the Indian Health Service, a tribal health care provider, or an urban Indian health care provider (see page 5) to:

**Health Insurance Marketplace – Exemption Processing**  
**465 Industrial Blvd.**  
**London, KY 40741**

#### What happens next?

Send your complete, signed application with required documents to the address above. We'll follow up with you within 1–2 weeks. You may receive a call from the Marketplace if we need more information. You'll get an eligibility determination letter in the mail after we process your exemption application. If you qualify for this exemption, we'll give you an Exemption Certificate Number (ECN) that you'll put on your federal income tax return. If you don't hear from us, call the Health Insurance Marketplace Help Center at **1-800-318-2596**. TTY users should call **1-855-889-4325**.

**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. The valid OMB control number for this information collection is 0938-1190. The time required to complete this information collection is estimated to average 16 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.

 **NEED HELP WITH YOUR APPLICATION?** Visit [HealthCare.gov](https://www.healthcare.gov), or call us at **1-800-318-2596**. Para obtener una copia de este formulario en Español, llame **1-800-318-2596**. 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. TTY users should call **1-855-889-4325**.



## STEP 5: Documents to support your application.

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In order to approve an exemption, we need documentation of membership in an Indian tribe, Alaska Native corporation, or eligibility for services through an Indian health care provider for each person who is asking for an exemption on this application.

Please submit **copies** of documents (**not** originals) based on your status or eligibility type as described below. **Be sure to make copies of both sides and all pages of the documents you submit.**

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### Member of an Indian tribe or shareholder in an Alaska Native corporation.

Submit **ONE** of the following:

- Enrollment or membership document from a federally-recognized tribe or the Bureau of Indian Affairs (BIA). It must be on **tribal letterhead** or an enrollment/membership card that contains the **tribal seal** and/or an **official signature**, or a Certificate of Degree of Indian Blood (CDIB) issued by the BIA or a tribe, **if the CDIB includes tribal enrollment information**.
  - Document issued by an Alaska Native village/tribe, or an Alaska Native Corporation Settlement Act (ANCSA) regional or village corporation acknowledging **descent**, or **affiliation**, or **shareholder status**, or **participation** in village or Alaska Native community affairs. The document can also include a CDIB issued by the BIA or tribe, **if the CDIB includes ANCSA shareholder status or information regarding membership** in an Alaska Native village.
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### Other individual who is eligible for services through an Indian health care provider.

Submit **ONE** of the following:

- If you are a California Indian, a document from the Bureau of Indian Affairs (BIA) or an Indian tribe, showing a person who is listed on the plans for distribution of the assets of Rancherias and reservations located within the state of California under the Act of August 18, 1958, and any **descendant** of such an Indian; or document showing trust interests in public domain, national forest, or reservation allotments in California; or document showing a person is a **descendant** of an Indian who was residing in California on June 1, 1852, if such **descendant** is a member of the Indian community served by a local program of the Indian Health Service; and is regarded as an Indian by the community in which such **descendant** lives.
- Letter on facility **letterhead with official signature** from the Indian Health Service, tribal or urban Indian health care provider verifying eligibility for services.
- Tribal document acknowledging **membership, descent, participation** in tribal community affairs, **residence** on tax exempt land, or that it regards the person as Indian. The document must be on **tribal letterhead**, and have a **tribal seal** or **official signature**.
- United States Bureau of Indian Affairs (BIA) Form 4432 **signed** by BIA or tribal official.
- Certificate of Degree of Indian Blood (CDIB), **signed** by BIA or tribal official.

**Or**, submit the following:

- Birth certificate **AND** a document from the list above for your parent or grandparent. If the document is from your grandparent, you must also provide a birth certificate linking your parent to your grandparent.
- Birth certificate or adoption papers **AND** a document from the list above for your eligible Indian parent or guardian.
- Marriage certificate, if non-Indian spouses are made eligible for services through an Indian health care provider, as a class, by an appropriate resolution of the governing body of the Indian tribe or tribal organization, **AND** a document from the list above for your eligible Indian spouse.
- If you are eligible for services through an Indian health care provider only because you are pregnant with the child of a member of an Indian tribe or a shareholder of an Alaska Native corporation, a document from the list above for the member or shareholder.
- If you are an urban Indian, a document showing residency in an urban Indian center, such as a rent statement, mortgage, utility bill, or voter registration card, **AND** an enrollment or membership card/ID or document establishing that the individual:
  - Is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the state in which they reside, or who is a descendant, in the first or second degree, of any such member;
  - Is an Eskimo or Aleut or other Alaska Native;
  - Is considered by the Secretary of the Interior to be an Indian for any purpose; or,
  - Has been determined to be an Indian under regulations promulgated by the Secretary.





# Appendix C

## Assistance with completing this application

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

Complete this section 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)	
<input type="text"/>	
2. First name, Middle name, Last name, & Suffix	
<input type="text"/>	
3. Organization name	
<input type="text"/>	
4. ID number (if applicable)	5. Agents/Brokers only: NPN number
<input type="text"/>	<input type="text"/>

### You can choose an authorized representative.

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 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. Name of authorized representative (First name, Middle name, Last name)		
2. Address		3. Apartment or suite number
<input type="text"/>		<input type="text"/>
4. City	5. State	6. ZIP code
<input type="text"/>	<input type="text"/>	<input type="text"/>
7. Phone number		
<input type="text"/> ( <input type="text"/> ) <input type="text"/> - <input type="text"/>		
8. Organization name		
<input type="text"/>		
9. ID number (if applicable)		
<input type="text"/>		

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.

10. Signature of PERSON 1 listed on this application	11. Date signed (mm/dd/yyyy)
<input type="text"/>	<input type="text"/>