Health Insurance Processing Center
P.O. Box 4405
Taunton, MA 02780-0419

You can get this information in large print and braille. Call **1-800-841-2900** from Monday to Friday, 8:00 A.M. to 5:00 P.M. **TTY:** 1-800-497-4648

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Mix Hoh
45 new Rd.
Boston, MA 02116

Date: August 04, 2016
Notice ID: 186448741/550/MIXED-HH-CV-030816
MassHealth Member ID: 00000000000
Health Connector Member ID: RefID_0000000000000
SSN: XXX-XX-1111

Important Notice about Your Health Coverage

Dear Mix Hoh,

We need you to complete the annual eligibility renewal for your household to make sure you are receiving the right type of coverage through MassHealth, the Children's Medical Security Plan (CMSP), the Health Safety Net (HSN), and the Massachusetts Health Connector.

For members of your household who are enrolled in MassHealth, Children's Medical Security Plan (CMSP), or Health Safety Net (HSN), we reviewed their information to see if we could automatically renew health coverage. **However, we are not able to renew current coverage for your household with the information we have.**

IMPORTANT FOR MASSHEALTH, CMSP AND HSN MEMBERS!

If you or people in your household do not respond to this notice by September 18, 2016 *your benefits may decrease or end.*

Members of your household who are enrolled through the Massachusetts Health Connector will be able to stay in their current coverage through December 31, **2016**. However, their coverage could also change in January **2017** if you do not respond and update your information.

We need you to contact us by **September 18, 2016** to update information about your household. Even if your information hasn't changed, you still need to contact us by **September 18, 2016** or you could have a change to or lose your benefits.

For MassHealth, CMSP or HSN members in your household

If you do not respond to this notice by September 18, 2016, the benefits for the following member(s) may decrease or end.

Household Member	Date of Birth	MassHealth Member ID
Hoh Wif	01-01-1998	000000000000

If you do not respond, we will use available federal and state data sources to decide if they qualify. This means that they could qualify for a different coverage with fewer benefits or they could no longer qualify for MassHealth, CMSP or HSN at all.

For Health Connector members in your household

We also need to make sure that we have the right information about your household before we can renew coverage for members of your household who are enrolled through the Health Connector. The following kinds of information will affect the type of Health Connector coverage you qualify for next year:

- **The number of people in your household** (this could be your family, or the people you include on your tax return).
- **Your income.** For privacy reasons, we can't show your income information for next year as a dollar amount. Instead, we show your current and expected income as a percentage of the Federal Poverty Level (FPL).
- **Your access to other health insurance.** For example, Medicare or a health plan offered by your job.

Please compare the Expected 2017 Federal Poverty Level (FPL) listed below with your household's expected income and size for next year, using the FPL chart at the end of this letter.

Household Member	Date of Birth	Current FPL	Expected 2017 FPL	Current Coverage Type	Expected 2017 Coverage Type
Hoh Mix	01-01-1970	462.49	811.49	Health Connector Plans	Health Connector Plans

If you haven't updated your account information recently, we may have used federal or state data sources for the information about your expected FPL and eligibility for next year. However, you can make changes to your information when you respond to this notice, if you think the information that we have isn't right. If you update your information, you may get another letter asking you to send in proof of the changes you've made.

- Any changes to your Health Connector eligibility and enrollment will not start until **January 1, 2017**. You will stay in your current coverage through December 31 as long as you continue to pay your monthly bill and don't have a change in eligibility before the end of the year. However, if your Expected Eligibility for 2017 is MassHealth, those benefits may start sooner.

What you need to do

1. **Review the information about your household**
   You will find the information from your household's application for health coverage on the form called *Massachusetts Renewal Application for Health and Dental Coverage and Help Paying Costs* that came with this letter.

2. **Update your information or tell us that nothing has changed**
   Even if your information hasn't changed, you will still need to respond by August 03, 2016, or your MassHealth, CMSP or HSN eligibility could decrease or end.

   Choose one of the following ways to either update your information or confirm that nothing has changed:

➢ **Online(Recommended):** The fastest way to renew health coverage for your household is online through our website at MAhealthconnector.org. Renewing your household's information online allows you to see right away if you still qualify.

- Go to the My Eligibility section of the website and choose the **Year 2016** application to review
- Go to https://qa-ind.mahealthconnector.optum.com/individual/validateClient?invitationCode=485338103596637007463941652333 where you will be able to create an account and see your renewal information.

- Review each page of your application and update any information that has changed. Click "Save and Continue" on each page until you've submitted your application on the Rights and Responsibilities page.
- **Make sure you submit any additional documentation requested on the eligibility results page**

➢ **Phone:** Call us at 1-800-841-2900 (TTY: 1-800-497-4648 for people who are deaf, hard of hearing, or speech disabled). We can help you complete your household renewal over the phone.

➢ **Paper:** Review and follow the instructions on the form called Massachusetts Renewal Application for Health and Dental Coverage and Help Paying Costs included with this letter. Send us the paper form by:

- **Fax.** Send all pages to 1-857-323-8300
- **Mail.** Send all pages to:

  Commonwealth of Massachusetts
  Health Insurance Processing Center
  P.O. Box 4405
  Taunton, MA 02780

➢ **In person:**

- Call us at 1-800-841-2900 (TTY: 1-800-497-4648) to find a MassHealth Enrollment Center (MEC) near you. You can also look in the Member Booklet for a list of MEC addresses.
- You can get free in-person help from a Navigator or a Certified Application Counselor. These people have been trained and certified to answer your questions and to help you complete your application. For a full list of Navigators and Certified Application Counselors, go to www.MAhealthconnector.org/help-center.

3. Send us proof if you haven't yet

We are still in the process of verifying that the people in your household qualify for coverage. When you applied, you should have gotten another letter telling you the type of information or proof that we are missing. You can also find this information in your online account.

If you have not already sent us proof, please send us the documents that we need as soon as possible so that you do not lose your health or dental insurance coverage. Learn more about sending proof at: www.MAhealthconnector.org/verification-documents

What happens next?

For MassHealth, CMSP or HSN members in your household

You will keep your household's current MassHealth coverage for up to 45 days from the date of this letter while we wait for you to renew your information.

Once we receive your completed renewal application, we will send you another letter to let you know if you and members of your household still qualify for health coverage through MassHealth, CMSP, or HSN. If you do not qualify for MassHealth, CMSP or HSN, we will determine if you qualify for coverage through the Health Connector.

We will check the information you give us with available federal and state data sources. We will keep the information provided to us private, and will only use and disclose it in accordance with applicable law. If we need more information, we will contact you.

For Health Connector members in your household

Your current Health Connector coverage will continue through December 31, 2016, as long as you continue to pay your monthly premium and don't have a change in eligibility before the end of the year. If there is a change in the type of coverage you qualify for in 2017, that change will start January 1, 2017. However, if your Expected Eligibility for 2017 is MassHealth, those benefits may start sooner.

We will send you another packet of information this October or November with information about renewing into a health plan for 2017. If you want to change health plans for next year, you will be able to shop for a new plan during Open Enrollment. This year's Open Enrollment period will be from November 01, 2016 to January 31, 2017.

What else do you need to know?

- **Update your information if it changes at any time of the year**
  Throughout the year, you must tell us about any change in your household's information as soon as possible. **You will need to report changes no later than 10 days** from the date of the change. This includes any changes to your household's income, address, phone number, household size, job, or health insurance.

- **The Member Booklet has more information about MassHealth**
  The ***Member Booklet*** explains income rules, premiums, and covered services for MassHealth. It also explains in more detail how we count your household members and income. To get a copy of the Member Booklet, you can go to mass.gov/masshealth or you can call the **MassHealth Customer Service Center** at **1-800-841-2900** (TTY: 1-800-497-4648 for people who are deaf, hard of hearing, or speech disabled).

What if you have questions?

If you have questions or need more information, go to MAhealthconnector.org or call the **MassHealth Customer Service** Center at **1-800-841-2900** (TTY: 1-800-497-4648 for people who are deaf, hard of hearing, or speech disabled).

Thank you,

Federal Poverty Level (FPL) chart for 2017 Health Connector Coverage

You can compare the Federal Poverty Level (FPL) amount that is listed on this notice to the chart below to make sure that the income range for your household is correct. Your household size should include the number of people that you include on your tax return.

If you think the FPL that we have for you is not correct, please make sure your household size and income is up to date when you respond to this renewal notice.

Federal Poverty Level (FPL) Income Guidelines for Health Connector Coverage Types						
Household Size	**100% FPL** ConnectorCare Plan Type 1	**150% FPL** ConnectorCare Plan Type 2A	**200% FPL** ConnectorCare Plan Type 2B	**250% FPL** ConnectorCare Plan Type 3A	**300% FPL** ConnectorCare Plan Type 3B	**400% FPL** Tax Credit only
1	$11,880	$17,820	$23,760	$29,700	$35,640	$47,520
2	$16,020	$24,030	$32,040	$40,050	$48,060	$64,080
3	$20,160	$30,240	$40,320	$50,400	$60,480	$80,640
4	$24,300	$36,450	$48,600	$60,750	$72,900	$97,200
5	$28,440	$42,660	$56,880	$71,100	$85,320	$113,760
6	$32,580	$48,870	$65,160	$81,450	$97,740	$130,320
7	$36,730	$55,095	$73,460	$91,825	$110,190	$146,920
8	$40,890	$61,335	$81,780	$102,225	$122,670	$163,560
Add for each extra person	$4,160	$6,240	$8,320	$10,400	$12,480	$16,640

Massachusetts Renewal Application for Health and Dental Coverage and Help Paying Costs

Instructions

We need information about each person living in your household or listed on your tax return, including those who get MassHealth now and others who live in the household and do not get MassHealth.

1. Please read the information listed on this form carefully. It lists the information MassHealth has about you and members of your household.
2. Please cross out the information if it is incorrect and write the correct information in the **Updated Information** column. If you have any missing information for your current household members please write that in the **Updated Information** column.
3. Please answer all questions for you and members of your household.
4. If you have a new household member to add, please fill out all the questions in **Supplement E: Massachusetts Application for Health and Dental Coverage and Help Paying Costs—Additional Persons**
5. Please sign the form and send **ALL PAGES** to
   Commonwealth of Massachusetts
   Health Insurance Processing Center
   P.O. Box 4405
   Taunton, MA 02780
   Fax to 1-857-323-8300

General Information		
Person 1 (Head of Household) —General Information	**Current Information**	**Updated Information**
Name (First Name, Middle Name, Last Name)	mix hoh	
SSN	XXX-XX-1111	
Sex	Male	
Date of Birth	01/01/1970	
Home Address	45 new Rd. Boston, MA 02116	
Mailing Address	45 new Rd. Boston, MA 02116	

General Information		
Person 1 (Head of Household) —General Information	**Current Information**	**Updated Information**
Do you intend to reside in Massachusetts, even if you do not have a fixed address?	Yes	
Primary Phone Number	000-000-0000	
Second Phone Number	None	
Email	Not Available	
Preferred Spoken Language	English	
Preferred Written Language	Spanish	
Are you seeking to continue coverage NEXT YEAR?* NOTE: *If you have coverage today and still need it for the next year, answer yes.*	Yes	
Is this individual a US Citizen or US National?	Yes	
Is this person a naturalized Citizen?	No	

General Information		
Person 2 — General Information	**Current Information**	**Updated Information**
Name (First Name, Middle Name, Last Name)	wif hoh	
SSN	XXX-XX-2222	
Sex	Female	
Date of Birth	01/01/1998	
Residing with HOH	Yes	

General Information		
Person 2 — General Information	**Current Information**	**Updated Information**
If not living with HOH, current address?	Not Available	
a. Are you living outside of Massachusetts temporarily?	Not Available	
b. If temporarily living outside of the state, where will you be living in Massachusetts?	Not Available	
Do you intend to reside in Massachusetts, even if you do not have a fixed address?	Yes	
Are you seeking to continue coverage NEXT YEAR?* NOTE: *If you have coverage today and still need it for the next year, answer yes.*	Yes	
Is this individual a US Citizen or US National?	No	

Household Relationships

Instructions: Below are the household relationships we have for you and your household on file. Please review the information below. If you have any changes to your own or your household's relationships please cross out the information if it is incorrect and write the correct information in the Updated Information Column.

Household Relationship				
Name	**DOB**	**Relationship**	**With Member**	**Updated Information**
mix hoh	01/01/1970	Is the Spouse of	wif hoh	
wif hoh	01/01/1998	Is the Spouse of	mix hoh	

Tax Filing Information

Instructions: Below is the tax filing information we have for you and your household on file. Please review the information below. If you have any changes to your own or your household's tax filing status please cross out the information if it is incorrect and write the correct information in the Updated Information Column.

Tax Filing Information		
Person 1— Tax Filing Information	**Current Information**	**Updated Information**
Person 1 (HOH)	mix hoh	
DOB	01/01/1970	
Are you planning to file federal income taxes NEXT YEAR? **Note:** You may not have needed or chosen to file a federal income tax return in the past, but you will have to file a federal income tax return for any year that you get an Advance Premium Tax Credit. You must check 'Yes' to get ConnectorCare or Advance Premium Tax Credit to help pay for your health insurance	Yes	
Are you considered married for tax filing purposes?	Yes	
a. Do you plan to file a joint federal income tax return with your spouse? **Important:** You must file a joint income tax return with your spouse to qualify for certain programs, unless you are a victim of domestic abuse or abandonment.	Yes	
b. Spouse's Name	wif hoh	
c. Spouse's Date of Birth	01/01/1998	
d. Do you live with spouse?	No	

Tax Filing Information		
Person 1— Tax Filing Information	**Current Information**	**Updated Information**
Will you claim any dependents on your federal income tax return?	No	
Will you be claimed as a dependent on someone else's federal income tax return for 2016?	No	
a. Tax filer's Name	Not Available	
b. Tax filer's Date of birth	Not Available	
c. Is Tax filer considered married for tax filing purposes?	Not Available	
i. Spouse's Name	Not Available	
ii. Spouse's Date of birth	Not Available	
d. Relationship to tax filer	Not Available	
Do you live with Tax Filer and or spouse of the Tax Filer?	No	
Does Tax Filer and or Spouse of Tax Filer plan to file income tax jointly?	No	
Does Tax Filer and or Spouse of Tax Filer claim any dependent for next year?	No	
a. Dependent's Name	Not Available	
b. Dependent's Date of birth	Not Available	
c: Relationship to Spouse of Tax Filer	Not Available	
Do you live with son, daughter, stepson, or daughter?	No	
a. Dependent's Name	Not Available	

Tax Filing Information		
Person 1— Tax Filing Information	**Current Information**	**Updated Information**
b: Dependent's Date of birth	Not Available	

Tax Filing Information		
Person 2— Tax Filing Information	**Current Information**	**Updated Information**
Person 2	wif hoh	
DOB	01/01/1998	
Are you planning to file federal income taxes NEXT YEAR? **Note:** You may not have needed or chosen to file a federal income tax return in the past, but you will have to file a federal income tax return for any year that you get an Advance Premium Tax Credit. You must check 'Yes' to get ConnectorCare or Advance Premium Tax Credit to help pay for your health insurance	No	
Are you considered married for tax filing purposes?	Yes	
a. Do you plan to file a joint federal income tax return with your spouse? **Important:** You must file a joint income tax return with your spouse to qualify for certain programs, unless you are a victim of domestic abuse or abandonment.	Yes	
b. Spouse's Name	mix hoh	
c. Spouse's Date of Birth	01/01/1970	

Tax Filing Information		
Person 2— Tax Filing Information	**Current Information**	**Updated Information**
d. Do you live with spouse?	No	
Will you claim any dependents on your federal income tax return?	No	
Will you be claimed as a dependent on someone else's federal income tax return for 2016?	No	
a. Tax filer's Name	Not Available	
b. Tax filer's Date of birth	Not Available	
c. Is Tax filer considered married for tax filing purposes?	Not Available	
i. Spouse's Name	Not Available	
ii. Spouse's Date of birth	Not Available	
d. Relationship to tax filer	Not Available	
Do you live with Tax Filer and or spouse of the Tax Filer?	No	
Does Tax Filer and or Spouse of Tax Filer plan to file income tax jointly?	No	
Does Tax Filer and or Spouse of Tax Filer claim any dependent for next year?	No	
a. Dependent's Name	Not Available	
b. Dependent's Date of birth	Not Available	
c: Relationship to Spouse of Tax Filer	Not Available	
Do you live with son, daughter, stepson, or daughter?	No	

Tax Filing Information		
Person 2— Tax Filing Information	**Current Information**	**Updated Information**
a. Dependent's Name	Not Available	
b: Dependent's Date of birth	Not Available	

Immigration Information

Instructions: Below is the immigration information we have for you on file. Please review the information below, if you have any changes to your current immigration status, please cross out the information if it is incorrect and write the correct information in the Updated Information Column. If your immigration status has changed please fill in the blank section below entitled **Updated Immigration Information.**

Immigration Information		
Person 2— Immigration Information	**Current Information**	**Updated Information**
Person 2	wif hoh	
DOB	01/01/1998	
Do you have an eligible immigration status?	No	
Did you arrive in the U.S. AFTER August 22, 1996?	Not Available	
Are you an honorably discharged veteran or active duty member of the military or the spouse or child of an honorably discharged veteran or active duty member of the military?	Not Available	

Updated Immigration Information

Instructions: If you have a new immigration status, please fill in as much of the information below as you have available. If you have more than one member in your household who has a new immigration status, please copy this page and fill it out for each household member needing to report a new status and attach it to the renewal form when you return it.

Updated Immigration Information		
Member—Updated Immigration Information	**Information**	**Notes**
Member Name:		
DOB:		
Do you have an eligible immigration status? (See the Member Booklet or Mahealthconnector.org for more information)		If you do not have an eligible immigration status or choose not to respond, you may only get one or more of the following: MassHealth Standard (if pregnant), MassHealth Limited, the Children's Medical Security Plan (CMSP), or the Healthy Safety Net (HSN).
If you do have an eligible immigration status, please answer the following:		
Do you have an immigration document?		It may help us to process this application faster if you include a copy of this person's immigration document with the application.
a. Immigration Status		
b. Document Type		
c. Status Award date		For battered persons, the status award date is the date the petition was approved as properly filed.

Updated Immigration Information		
Member—Updated Immigration Information	**Information**	**Notes**
d. Document ID Number		
e. I-94 Number		
f. Alien Number		
g. Passport or document expiration date		
h. Country of issue		
i. Receipt/Card Number/SEVIS Number		
j. Visa Number		
k. Other documentation		
Is your name listed above the same name that appears on your document?		
IF NO: please provide name		
Did you arrive in the U.S. AFTER August 22, 1996?		
Are you an honorably discharged veteran or active duty member of the military or the spouse or child of an honorably discharged veteran or active duty member of the military?		

Additional Information

Instructions: Below is additional information we have for you and your household on file. Please review the information below. If you have any changes to you or your household's information, please cross out the information that is incorrect and write the correct information in the Updated Information Column.

Additional Information		
Person 1— Additional Information	**Current Information**	**Updated Information**
Person 1 (HOH)	mix hoh	
DOB	01/01/1970	
Does this person live with at least one child under age 19 and is he/she the main person taking care of that child?	No	
a. Dependent's Name	Not Available	
b. Dependent's Date of birth	Not Available	
Is this person of Hispanic, Latin or Spanish origin? (optional)	No	
a. Ethnicity (optional)	Not Available	
b. Race(optional)	Not Available	
Does this person have an injury, illness, or disability (including mental health condition) that has lasted or is expected to last for at least 12 months? If legally blind, answer YES	No	
Is this person an American Indian/ Alaska Native? Note: If you are newly attesting to being an American Indian or Alaskan Native, please complete Supplement B: American Indian/ Alaskan Native.	Not Available	
a. Tribe Name?	Not Available	

Additional Information		
Person 1— Additional Information	**Current Information**	**Updated Information**
b. State affiliation of tribe?	Not Available	
Does this person have breast or cervical cancer? (optional)	No	
Is this person HIV positive? (optional)	No	
Does this person need reasonable accommodation because of a disability or an injury? If you are newly attesting to needing reasonable accommodations, please complete Supplement C: Accommodations.	No	

Additional Information		
Person 2— Additional Information	**Current Information**	**Updated Information**
Person 2	wif hoh	
DOB	01/01/1998	
Does this person live with at least one child under age 19 and is he/she the main person taking care of that child?	Not Available	
a. Dependent's Name	Not Available	
b. Dependent's Date of birth	Not Available	
Is this person of Hispanic, Latin or Spanish origin? (optional)	No	
a. Ethnicity (optional)	Not Available	
b. Race(optional)	Not Available	

Additional Information		
Person 2— Additional Information	**Current Information**	**Updated Information**
Does this person have an injury, illness, or disability (including mental health condition) that has lasted or is expected to last for at least 12 months? If legally blind, answer YES	No	
Is this person an American Indian/ Alaska Native? Note: If you are newly attesting to being an American Indian or Alaskan Native, please complete Supplement B: American Indian/ Alaskan Native.	Not Available	
a. Tribe Name?	Not Available	
b. State affiliation of tribe?	Not Available	
Is this person pregnant?	No	
a. if YES, How many babies is this person expecting during pregnancy?	Not Available	
b. if YES, what is the expected DUE Date	Not Available	
Was this person ever in foster care?	No	
a. In what state was this person in the foster care system?	Not Available	
b. Was this person getting health coverage through a state Medicaid program?	Not Available	
Does this person have breast or cervical cancer? (optional)	No	
Is this person HIV positive? (optional)	No	

Additional Information		
Person 2— Additional Information	**Current Information**	**Updated Information**
Does this person need reasonable accommodation because of a disability or an injury? If you are newly attesting to needing reasonable accommodations, please complete Supplement C: Accommodations.	No	

INCOME INFORMATION

Instructions: Below is the income information we have for you and your household on file. Please review the information below. If you have any changes to your current income, please cross out the information if it is incorrect and write the correct information in the Updated Information Column. If you have a new job or source of income please fill in the blank section below entitled **Updated Income Information.**

INCOME INFORMATION		
Person 1— Income Information	**Current Information**	**Updated Information**
Person 1 (HOH)	mix hoh	
DOB	01/01/1970	
Does this person have Income?	Yes	
Job Income		
Name of Employer	Ddddd	
Employer Address	23 dsadsadsad boston, MA 02110	
How much does this person get paid (before taxes are taken out)? Note: You should also tell us here about a one-time amount you got from a current or former employer this month. If you have seasonal income please enter the monthly amount received	$52,965	

INCOME INFORMATION		
Person 1— Income Information	**Current Information**	**Updated Information**
How often does this person get this amount?	Yearly	
How many hours does this person work per week?	40.0	
Is this a sheltered workshop?	No	
If seasonally employed, the months in which the income is earned.	Not Available	
Is this person's income steady from month to month?	Yes	
a. What is this person's expected average monthly income?	$4,413.75	
Person 1's (HOH) annual income for THIS YEAR is	$52,965	

INCOME INFORMATION		
Person 2— Income Information	**Current Information**	**Updated Information**
Person 2	wif hoh	
DOB	01/01/1998	
Does this person have Income?	Yes	
Job Income		
Name of Employer	Wwwww	
Employer Address	23 adsadsad boston, MA 02110	

INCOME INFORMATION		
Person 2— Income Information	**Current Information**	**Updated Information**
How much does this person get paid (before taxes are taken out)? Note: You should also tell us here about a one-time amount you got from a current or former employer this month. If you have seasonal income please enter the monthly amount received	$20,709	
How often does this person get this amount?	Yearly	
How many hours does this person work per week?	40.0	
Is this a sheltered workshop?	No	
If seasonally employed, the months in which the income is earned.	Not Available	
Is this person's income steady from month to month?	Yes	
a. What is this person's expected average monthly income?	$1,725.75	
Person 2's annual income for THIS YEAR is	$20,709	

Updated Income Information

Instructions: Use this section if there are additional jobs or income that you or any of your household members now have. If you need more space copy this page and attach it to the renewal form when you return it.

UPDATED INCOME INFORMATION		
Questions	**New Job/Income1**	**New Job/Income2**
Member Name		
DOB		
New Job		
Employee Name and Address		
Wages/tips (before taxes)		
Frequency you get paid (weekly, bi-weekly, monthly, seasonally, semi-monthly)		
Average number of hours worked each week		
Is this job a sheltered workshop?		
Are you seasonally employed? If yes, answer question a. below.		
a. If yes, how many months do you work each calendar year?		
Are you newly self-employed? If yes, answer questions a. and b. below.		
a. If yes, what type of work do you do?		
b. On average, how many months do you work each calendar year?		
Other Income		

UPDATED INCOME INFORMATION		
Questions	**New Job/Income1**	**New Job/Income2**
Member Name		
DOB		
Type of Income In the space provided to the right, please list the type of income: Social Security, Unemployment, Retirement, Capital Gains, Investment Income, Net rental or royalty income, net farming or fishing income, alimony received, or other		
a. Amount		
b. How Often? - If one time, please list month it was received		
Type of Income		
a. Amount		
b. How Often? - If one time, please list month it was received		
Type of Income		
a. Amount		
b. How Often? - If one time, please list month it was received		
Type of Income		
a. Amount		
b. How Often? - If one time, please list month it was received		
INCOME DEDUCTIONS		

UPDATED INCOME INFORMATION		
Questions	**New Job/Income1**	**New Job/Income2**
Member Name		
DOB		
Type of Deduction In the space provided to the right please list the type of deductions: Alimony paid, Student loan interest, other tax deduction		
a. Amount		
b. How often?		
Type of Deduction		
a. Amount		
b. How often?		

Health Insurance Information

Instructions: Below is the health insurance information we have for you and your household on file. Please review the information below. If you have any changes to your current health insurance information, please cross out what is incorrect and write the correct information in the Updated Information Column. If you have access to new health insurance please fill out the **Supplement A: Health Coverage from Jobs.**

Health Insurance Information		
Person 1— Health Insurance Information	**Current Information**	**Updated Information**
Person 1 (HOH)	mix hoh	
DOB	01/01/1970	
Is this person offered health insurance coverage through a job (even if it's from another person's job like a spouse)?	No	
Date this person could start coverage	Not Available	
Employer Name	Not Available	
Federal Tax ID	Not Available	
Employer Address	Not Available	
Employer Phone Number	Not Available	
Email	Not Available	
Will this person be enrolled in a health plan offered by the employer during the time period he/she is applying for coverage?	No	
Date this person will be covered by the employer's plan	Not Available	

Health Insurance Information		
Person 1— Health Insurance Information	**Current Information**	**Updated Information**
Does this person expect any changes in his employer's health coverage next year?	Not Available	
What is the name of the lowest-cost health plan offered to this person? Note: only include the individual plan, not the family plan offered by the employer.	Not Available	
Is the lowest-cost individual plan considered affordable?	Not Available	
How much would this person pay in premiums to enroll in this plan?	Not Available	
How often would this person pay this amount?	Not Available	
Will this person be enrolled in health coverage from COBRA, Retiree Health Plan, or Veterans Health Program?	No	
a. Coverage Start Date?	Not Available	
b. Coverage End Date?	Not Available	
Is this person eligible for health coverage through Medicare, TRICARE Federal Employees Health Benefit Program, Peace Corps, or VA Healthcare Program?	No	
a. Coverage Start Date?	Not Available	
b. Coverage End Date?	Not Available	

Health Insurance Information		
Person 1— Health Insurance Information	**Current Information**	**Updated Information**
Is this person offered the Massachusetts state employee health benefit plan through a job or a family member's job?	No	

Health Insurance Information		
Person 2— Health Insurance Information	**Current Information**	**Updated Information**
Person 2	wif hoh	
DOB	01/01/1998	
Is this person offered health insurance coverage through a job (even if it's from another person's job like a spouse)?	No	
Date this person could start coverage	Not Available	
Employer Name	Not Available	
Federal Tax ID	Not Available	
Employer Address	Not Available	
Employer Phone Number	Not Available	
Email	Not Available	
Will this person be enrolled in a health plan offered by the employer during the time period he/she is applying for coverage?	No	
Date this person will be covered by the employer's plan	Not Available	

Health Insurance Information		
Person 2— Health Insurance Information	**Current Information**	**Updated Information**
Does this person expect any changes in his employer's health coverage next year?	Not Available	
What is the name of the lowest-cost health plan offered to this person? Note: only include the individual plan, not the family plan offered by the employer.	Not Available	
Is the lowest-cost individual plan considered affordable?	Not Available	
How much would this person pay in premiums to enroll in this plan?	Not Available	
How often would this person pay this amount?	Not Available	
Will this person be enrolled in health coverage from COBRA, Retiree Health Plan, or Veterans Health Program?	No	
a. Coverage Start Date?	Not Available	
b. Coverage End Date?	Not Available	
Is this person eligible for health coverage through Medicare, TRICARE Federal Employees Health Benefit Program, Peace Corps, or VA Healthcare Program?	No	
a. Coverage Start Date?	Not Available	
b. Coverage End Date?	Not Available	

Health Insurance Information		
Person 2— Health Insurance Information	**Current Information**	**Updated Information**
Is this person offered the Massachusetts state employee health benefit plan through a job or a family member's job?	No	

Read and Sign this Renewal Application

On behalf of myself and all persons listed on this renewal application, I understand, represent, and agree as follows.

1. MassHealth may require eligible persons to enroll in available employer-sponsored health insurance if that insurance meets the criteria for MassHealth payment of premium assistance.
2. Employers of eligible persons may be notified and billed in accordance with MassHealth regulations for any services that hospitals or community health centers provide to such persons that are paid for by the Health Safety Net.
3. Eligible persons may have to pay a premium for health coverage for themselves and others listed on this renewal application. Failure to pay any premium due may result in the state deducting the amount owed from the tax refunds of responsible persons. If an eligible person is a certain American Indian or Alaska Native, such person may not have to pay premiums for MassHealth.
4. MassHealth has the right to pursue and get money from third parties who may be obligated to pay for health services provided to eligible persons enrolled in MassHealth programs. Such third parties may include other health insurers, spouses, or parents obligated to pay for medical support, or individuals obligated to pay under accident settlements. Eligible persons must cooperate with MassHealth in establishing third-party support and obtaining third-party payments for themselves and anyone whose rights they can legally assign. Eligible persons may be exempted from this obligation if they believe and tell MassHealth that cooperation could result in harm to them or anyone whose rights they can legally assign.
5. A parent and/or guardian of minor children must agree to cooperate with state efforts to collect medical support from an absent parent unless they believe and tell MassHealth that cooperation will harm the children or the parent or guardian.
6. Eligible persons who are injured in an accident, or in some other way, and get money from a third party because of that accident or injury must use that money to repay MassHealth or the Health Safety Net for certain services provided.
7. Eligible persons must tell MassHealth or the Health Safety Net, in writing, within 10 calendar days, or as soon as possible, about any insurance claims or lawsuits filed because of an accident or injury.

8. The status of this renewal application may be shared with a hospital, community health center, other medical provider, or federal or state agencies when necessary for treatment, payment, operations, or the administration of the programs listed above.
9. To the extent permitted by law, MassHealth may place a lien against any real estate owned by eligible persons or in which eligible persons have a legal interest. If MassHealth puts a lien against such property and it is sold, money from the sale of that property may be used to repay MassHealth for medical services provided.
10. To the extent permitted by law, for any eligible person age 55 or older, or any eligible person for whom MassHealth helps pay for care in a nursing home, MassHealth may seek money from the eligible person's estate after death.
11. MassHealth, the Health Connector, and the Health Safety Net will obtain from eligible persons' current and former employers and health insurers all information about health insurance coverage for such persons. This includes, but is not limited to, information about policies, premiums, coinsurance, deductibles, and covered benefits that are, may be, or should have been available to such persons or members of their household.
12. MassHealth, the Health Connector, and the Health Safety Net may get records or data about persons listed on this renewal application from federal and state data sources and programs, such as the Social Security Administration, the Internal Revenue Service, the Department of Homeland Security, the Department of Revenue, and the Registry of Motor Vehicles, as well as private data sources, 1) to prove any information given on this renewal application and any supplements, or other information given once a person becomes a member, 2) to document medical services claimed or provided to such persons, and 3) to support continued eligibility.
13. To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow the Health Connector to use income data, including information from tax returns for the next coverage year (2017). The Health Connector will send me a notice, let me make changes, and I can opt out at any time. I understand that if I am eligible for an Advance Premium Tax Credit (APTC) and/or Reduced Copays and Deductibles these payments will be made directly to my selected insurance carrier(s). Acceptance of APTC and/or Reduced Copays and Deductibles may impact my 2016 tax liability. I will be given the option to apply all, some, or none of any APTC amount I may be eligible for to my monthly premium.
14. In connection with the eligibility and enrollment process, MassHealth, the Health Connector, and the Health Safety Net may send notices that contain personal information about persons listed on this renewal application to other persons on this renewal application, or otherwise communicate such information to such persons.
15. Under federal law, discrimination is not 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 going to www.hhs.gov/ocr/office/file.
16. Eligible persons must tell the health care program(s) in which they enroll about any changes in their or their household's income or employment, household size, health insurance coverage, health insurance premiums, and immigration status, or about changes in any other information on this renewal application and any supplements to it within 10 calendar days of learning of the change. Eligible persons can make changes by

calling 1-888-665-9993 (TTY: 1-888-665-9997 for people who are deaf, hard of hearing, or speech disabled). A change in information could affect eligibility for such persons or for persons in their household.

- Sign on to your account at **MAhealthconnector.org.** You can create an online account if you do not already have one.
- Send the change information to
  Health Insurance Processing Center
  P.O. Box 4405
  Taunton, MA 02780
- Fax the change information to 1-857-323-8300.

17. No one applying for health coverage on this renewal application is in prison or in jail except as set forth below. If someone applying for health coverage is in prison or jail, write their name below and answer the following three questions.

_____ is in prison or jail.

Is this person awaiting trial? □ Yes □ No

Is this person being released within 30 days of submitting this renewal application? □ Yes □ No

Is this person an inmate who will be admitted to a hospital for at least 24 hours and then returned to prison or jail? □ Yes □ No

I AGREE TO THE FOLLOWING STATEMENTS

- I have read or have had read to me the information on this renewal application, including any supplements and instruction pages, and I understand that the Member Booklet contains important information.
- I have permission from all persons listed on this renewal application (or their parent or other legally authorized representative) to submit this renewal application and to act on their behalf to complete this renewal application and any ongoing or subsequent eligibility process and activity, including, for example:
  - providing personal information about them, including health, health coverage, and income information, seeing such information as may be provided by the Health Connector, MassHealth, and the Health Safety Net, and providing consent on their behalf to the use and disclosure of their information as described in this renewal application;
  - making choices about coverage options and methods of communication with the Health Connector, MassHealth, and the Health Safety Net;
  - making changes to the renewal application or related eligibility documents and providing information about any change in their circumstances; and
  - providing consent on their behalf to use government and private sources to verify information as described in this renewal application.
- I understand my rights and responsibilities and the rights and responsibilities of all persons listed on this renewal application as explained above
- I have told or will tell all such persons (or their parent or legally authorized representative, if applicable) about these rights and responsibilities so they understand them.

- I understand and agree that MassHealth, the Health Safety Net, and the Health Connector will treat electronic, faxed, or copies of signatures with the same force and effect as an original signature(s).
- The information I have supplied is correct and complete to the best of my knowledge about myself and other persons listed on this renewal application.
- I may be subject to penalties under federal law if I intentionally provide false or untrue information.

Sign this Renewal Application.
By signing this renewal application below, I hereby certify under the pains and penalties of perjury that the submissions and statements I have made in this renewal application are true and complete to the best of my knowledge, and I agree to accept and comply with the above rights and responsibilities.

Important: If you are submitting this application as an authorized representative, you must submit an **Authorized Representative Designation Form (ARD)** to us or have a form on record for us to process this application. The ARD is at the end of this application.

Signature of Person 1 (HOH) or authorized representative	
Print Name	Date

Voter Registration
The form to register to vote is included with this renewal application or can be found at www.sec.state.ma.us. More information on how to register to vote can also be found at www.sec.state.ma.us. If you have any questions about the voter registration process, or if you need help filling out the form, please visit a local MassHealth Enrollment Center or call the MassHealth Customer Service Center at 1-800-841-2900 (TTY: 1-800-497-4648 for people who are deaf, hard of hearing, or speech disabled).

Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency. If you would like help in filling out the voter registration application form, we will help you. The decision to seek or accept help is yours. You may fill out the application form in private.

If you believe that someone has interfered with your right to register or to decline to register to vote, with your right to privacy in deciding to register or in applying to register to vote, or with your right to choose your own political party or other political preference, you may file a complaint with:

Secretary of the Commonwealth, Elections Division
One Ashburton Place Room 1705
Boston, MA 02108
Tel: 617-727-2828 or 1-800-462-8683.

If you or anyone else in your application are not registered to vote where you live now, would you like to apply to register to vote today?
□ **Yes** □ **No**

IF YOU DO NOT CHECK EITHER BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.

Supplement A: Health Coverage from Jobs
Instructions: Complete the below information if someone in the household is newly eligible for health coverage from a job, but is not enrolled in the coverage. Attach a copy of this page for each job that offers coverage. If all eligible household members are enrolled in coverage offered by an employer, make sure that Health Insurance Information section above is complete, and skip this section.

Supplement A: Health Coverage from Jobs	
Health Coverage from Jobs Information	**Information**
Member Name	
DOB	
Employer Name	
Employer Address Address City State, Zip Code	
Employer Phone Number	
Employer Identification Number (if known)	
Who can we contact about employee health coverage at this job?	
Phone number (if different from above)	
Email Address	
Is this person currently eligible for coverage offered by this employer, or will this person become eligible within the next 3 months? - Answer yes or no **Note:**if yes, please answer all the questions below	
a. If this person is in a waiting or probationary period, when can this person enroll in coverage? (mm/dd/yyyy)	

Supplement A: Health Coverage from Jobs	
Health Coverage from Jobs Information	**Information**
b. List the names of anyone else on this application who is eligible for coverage from this job	
Does this employer offer health insurance that meets minimum value standard?* - Answer yes or no	
What is the name of the lowers cost self-only health plan offered by the employee?	
Is the lowest cost plan that meets minim value standard that is offered to the employee affordable as defined by the Affordable Care Act? - Answer yes or no **Note:**To figure out whether a plan meets the minimum value standard* or if a plan is considered affordable, refer to the Member Booklet.	
What change will the employer make in the new plan year (if known)?	□ Employer will not offer health coverage □Employer will start offering health coverage to employees or change the premium for the lowest- cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs.)
a. How much would the employee have to pay in premiums for this plan?	
b. How often? Note: weekly, every two weeks, twice a month, once a month, quarterly, yearly	
c. Date of change (mm/dd/yyyy)	

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986).

Supplement B: American Indian/Alaskan Native Status

Instructions: Complete this section if you or a household member are an American Indian or Alaska Native. American Indians and Alaska Natives can get services from the Indian Health Service, tribal health programs, or Urban Indian Health Programs. They also may not have to pay premiums or copayments and may get special monthly enrollment periods. Answer the following questions to make sure your household gets the most help possible. If you have more people to include, make a copy of this page and attach it.

Supplement B: American Indian/Alaskan Native Status		
American Indian/Alaskan Native Status	**Member 1**	**Member 2**
Member Name		
DOB		
Member of federally recognized tribe? if yes please answer a. and b. below.		
a. If yes, Tribe name		
b. If yes, Tribe affiliation		
Member of Massachusetts-recognized tribe? if yes please answer a. and b. below.		
a. If yes, Tribe name		
b. If yes, Tribe affiliation		
Has this person ever gotten a service from the Indian Health Service, a tribal health program, or Urban Indian Health Program, or through a referral from one of these programs?		
a. If no, is this person eligible to get services from the Indian Health Service, tribal health programs, or Urban Indian Health Programs, or through a referral from one of these programs?		

Supplement B: American Indian/Alaskan Native Status		
American Indian/Alaskan Native Status	**Member 1**	**Member 2**
Certain money received may not be counted for MassHealth. List any income (amount and how often) reported on your application that includes money from • Per capita payments from a 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 trust land by the Department of the Interior (including reservations and former reservations); or • Money from selling things that have cultural significance		
a. Income	$	
b. How often? Note: weekly, every two weeks, twice a month, once a month, quarterly, yearly		

Supplement C: Accommodations

Instructions: If you or anyone in your household answered Yes in Additional Information section needing reasonable accommodation because of a disability or injury, check all that apply below and list name(s):

1. Condition
   - □ Blind – Name(s):_____
   - □ Deaf – Name(s):_____
   - □ Developmentally Disabled – Name(s):_____
   - □ Hard of hearing – Name(s):_____
   - □ Intellectually Disabled – Name(s):_____
   - □ Low Vision – Name(s):_____
   - □ Physically Disabled – Name(s):_____
   - □ Other (Please explain) - Name(s):_____

2. Accommodation
   - □ American Sign Language (ASL) interpreter – Name(s):_____
   - □ Assistive Learning device – Name(s):_____
   - □ Communication Access Real-time Translations (CART) – Name(s):_____
   - □ Large print publications – Name(s):_____
   - □ Publications in electronic format – Name(s): _____
   - □ Publications in Braille – Name(s):_____
   - □ Text telephone – Name(s):_____
   - □ Video Relay Services (VRS) – Name(s):_____
   - □ Other (Please explain) - Name(s):_____

Supplement D: Authorized Representative Designation Form
You can submit this form if you would like to designate an authorized representative to act on your behalf. If an authorized representative signed your application for you, or if you are an authorized representative applying on behalf of someone else, you MUST submit this form for the application to be processed.

You do not need to fill out this form if you live in an institution and want copies of eligibility notices sent to you and to your spouse who still lives at home. We will do that automatically.

NOTE: An authorized representative has the authority to act on an applicant's or member's behalf in all matters with MassHealth and the Health Connector, and will receive personal information about the applicant or member until we receive a cancellation notice terminating their authority. Their authority will not automatically terminate once we process your application.

You can choose someone to help you.
You may choose an authorized representative to help you get health care coverage through programs offered by MassHealth and the Health Connector. You can do this by filling out this form (the Authorized Representative Designation Form) or a sufficiently similar designation document. You or a representative can sign for yourself and for any of your dependent children under the age of 18 for whom you are the custodial parent.

You are not required to have a representative in order to apply for or receive benefits.

Who can help me?

a. An authorized representative can be a friend, family member, relative, or other person or organization of your choosing who agrees to help you. It is up to you to choose an authorized representative if you want one. Neither MassHealth nor the Health Connector will choose an authorized representative for you. You must designate in writing (fill out Section I, Part A) the person or organization who you want to be your authorized representative. Your authorized representative must also fill out Section I, Part B.

b. If, because of a mental or physical condition, you cannot designate an authorized representative in writing, a person (not an organization) who is acting responsibly on your behalf can be your authorized representative if that person certifies, by filling out Section II, that you are not able to provide a written designation, and that he or she is acting responsibly on your behalf.

c. An authorized representative can also be someone who has been appointed by law to act on your behalf. This person must fill out Section III and either you or this person must submit to us, together with this form, a copy of the applicable legal document stating that this person is lawfully representing you.

d. A person appointed by law to act on behalf of the estate of an applicant or member who has died can also serve as an authorized representative by following the instructions above. An authorized representative under Section III may be a legal guardian, conservator, holder of power of attorney, or health care proxy, or, if the applicant or

member has died, the estate's administrator or executor. What this person is authorized to do for you or for the applicant or member's estate will depend on the wording of the legal appointment.

What can an authorized representative do?
An authorized representative may

- fill out your application or eligibility review forms;
- fill out other MassHealth or Health Connector eligibility or enrollment forms;
- give proof of information reported on these forms;
- report changes in income, address, or other circumstances;
- get copies of all of your MassHealth and Health Connector eligibility and enrollment notices; and
- act on your behalf in all other matters with MassHealth and the Health Connector

How does an authorized representative designation end?
If you decide that you no longer want a Section I or Section II authorized representative, you must notify us at the time you want the designation to end by doing the following.

- Mailing a letter notifying us that the designation has ended to
  Health Insurance Processing Center
  P. O. Box 4405
  Taunton, MA 02780;
- Faxing a letter notifying us that the designation has ended to 1-857-323-8300; or
- Calling us at 1-800-841-2900 (TTY: 1-800-497-4648 for people who are deaf, hard of hearing, or speech disabled).

If you mail or fax this notice to us, the notice must include your name, address, and date of birth, the name of your authorized representative, a statement that the designation has ended and your signature or, if you cannot provide written notice, the signature of someone acting on your behalf (in the case of a Section II authorized representative only).

In addition, if your authorized representative notifies us that such person or organization is no longer acting on your behalf, we will no longer recognize the person or organization as your authorized representative.
A Section III authorized representative's designation ends when his or her legal appointment ends. The authorized representative must notify us as instructed above.

In addition, an authorized representative's designation for a minor child ends on the child's 18th birthday.

Section 1: Authorized Representative Designation (if applicant or member is able to sign)

Part A — to be filled out by applicant or member. Please print, except for signature.
Please note: Your social security number (SSN) is required if one has been issued

Member's Name	SSN (if you have one)

Date of Birth (mm/dd/yyyy)	Member's e-mail address
I certify that I have chosen the following person or organization to be the authorized representative for myself and any dependent children under the age of 18 for whom I am the custodial parent and that I understand the duties and responsibilities this person or organization will have (as explained earlier in this form).	
Member's Signature	Date
Authorized representative's name	Authorized representative's phone number
Authorized representative's address (mailing address, city, state, zip)	

Part B—to be filled out by authorized representative. Please print, except for signature.

B1. COMPLETE IF AUTHORIZED REPRESENTATIVE IS A PERSON

I certify that I will at all times maintain the confidentiality of any information regarding the applicant or member set forth above and, if applicable, the dependent children of such applicant or member, that is provided to me by MassHealth or the Health Connector. If I am also a provider, staff member, or volunteer affiliated with an organization, and am acting in my capacity as a provider, staff member, or volunteer in connection with my designation as an authorized representative, I certify that I will at all times adhere to all applicable state and federal laws and regulations regarding confidentiality of information and conflicts of interest including those set forth at 42 C.F.R. part 431, subpart F, 42 C.F.R. § 447.10, and 45 C.F.R. § 155.260(f).

Authorized representative's signature	Date
Authorized representative's printed name	Authorized representative's email address

B2. COMPLETE IF AUTHORIZED REPRESENTATIVE IS AN ORGANIZATION

I certify, on behalf of the organization set forth below, that such organization will at all times maintain the confidentiality of any information regarding the applicant or member set forth above and, if applicable, the dependent children of such applicant or member, that is provided to the organization by MassHealth or the Health Connector. I, the provider, staff member, or volunteer of the organization set forth below, completing this form, certify on behalf of myself and on behalf of the organization I represent, that any providers, staff members, or volunteers acting on behalf of the organization in connection with this authorized representative designation will at all times adhere to all applicable state and federal laws and regulations regarding confidentiality of information, and conflicts of interest, including those set forth at 42 C.F.R. part 431, subpart F, 42 C.F.R. § 447.10, and 45 C.F.R. § 155.260(f).

Signature of provider, staff member, or volunteer completing form	Date
Printed name of provider, staff member, or volunteer completing form	
Email of provider, staff member, or volunteer completing form	Authorized representative organization name

Section 2: Authorized Representative Designation (if applicant or member cannot provide written designation)

To be filled out by authorized representative. Please print, except for signature. Please provide a separate form for each applicant or member.

AN ORGANIZATION IS NOT ELIGIBLE TO BE AN AUTHORIZED REPRESENTATIVE UNDER THIS SECTION.

I certify that I know enough about the applicant or member set forth below to take responsibility for the correctness of the statements made on his or her behalf during the eligibility process and in other communications with MassHealth or the Health Connector, that I understand my duties and responsibilities as this person's authorized representative (as explained earlier in this form), and that this person cannot provide written designation. If this person can understand, I have told the person that MassHealth and the Health Connector will send me a copy of all MassHealth and Health Connector eligibility and enrollment notices and this person agrees to this, and I have told this person that he or she may remove or replace me as his or her authorized representative at any time by the methods described earlier in this form.

I further certify that I will at all times maintain the confidentiality of any information regarding the applicant or member set forth below that is provided to me by MassHealth or the Health Connector.

Please note that the applicant's or member's social security number (SSN) is required if one has been issued.

Member's Name	
Member's Date of Birth (mm/dd/yyyy)	Member's SSN
Authorized representative's signature	Date (mm/dd/yyyy)
Authorized representative's name (first, middle, last)	Authorized representative's phone number

Authorized representative's Address (mailing address, city, state, zip)	Authorized representative's email address

Section 3: Authorized Representative Designation (if appointed by law)

To be filled out by an authorized representative appointed by law (as explained earlier on this form). Please print, except for signature. Please submit a copy of the applicable legal document with this form. I certify that I will at all times maintain the confidentiality of any information regarding the applicant or member as set forth below, that is provided to me by MassHealth or the Health Connector. Please note that the applicant's or member's social security number (SSN) is required if one has been issued.

Member's Name	
Member's Date of Birth (mm/dd/yyyy)	Member's SSN
Authorized representative's signature	Date (mm/dd/yyyy)
Authorized representative's name (first, middle, last)	Authorized representative's phone number
Authorized representative's Address (mailing address, city, state, zip)	Authorized representative's email address