coverME.gov
AFFORDABLE HEALTH COVERAGE FOR MAINE

Form Approved
OMB No. 0938-1191

Application for Health Coverage & Help Paying Costs: Families

THINGS TO KNOW

Use this application to see what coverage you qualify for

- Affordable private health insurance plans that offer comprehensive coverage to help you stay well
- A new tax credit that can immediately help pay your premiums for health coverage
- Free or low-cost insurance from Medicaid (MaineCare) or the Children's Health Insurance Program (CHIP- CubCare)

Who can use this application?

YOU CAN ONLY USE THIS APPLICATION IF YOU ARE AN ADULT WHO:

- Is not offered health coverage from their employer
- Is part of a family with more than one person applying for health coverage

NOTE: If you are single, you need to use the Individual Application Form to make sure you get the most benefits possible.

Apply faster online

Apply faster at **CoverME.gov**

What you may need to apply

- Your Social Security number (or document number if you're an eligible immigrant)
- Employer and income information (for example, from paystubs, W-2 forms, or wage and tax statements)

Why do we ask for this information?

We ask about income and other information to let you know what coverage you qualify for and if you can get any help paying for it.

We'll keep all the information you provide private and secure, as required by law. See the Privacy Act attached to this application.

What happens next?

Send your completed, signed application to the address on page 5 . **If you don't have all the information we ask for, sign and submit your application anyway.** We'll follow up with you within 1–2 weeks. Filling out this application doesn't mean you have to buy health coverage.

Get help with this application

- **Online:** CoverME.gov
- **Phone:** Call our Customer Assistance Center at 1-866-636-0355.
- **In person:** There may be trained experts in your area to help. Visit CoverME.gov or call 1-866-636-0355 for more information.

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 0938-1191. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Use blue or black ink to complete this application. If your family is larger than 2 individuals, please print out pages 6-8 of this application for each additional member of your family.

STEP 1 Tell us about yourself (Primary Applicant)

(We need one adult in the family to be the contact person for your application.)

1. First name | Middle name | Last name | Suffix

2. Home address (☐ Check this box if you are a Maine resident experiencing homelessness or have no permanent address.)

3. Apartment or suite number

4. City | 5. State | 6. ZIP code | 7. County (optional)

8. Mailing address (if different from home address)

9. Apartment or suite number

10. City | 11. State | 12. ZIP code | 13. County

14. Phone number ( ) –

15. Other phone number ( ) –

16. Do you want to get information about this application by email? ☐ Yes ☐ No

Email address: ____________________

17. What is your preferred spoken or written language (if not English)?

18. Date of birth (mm/dd/yyyy) / /

19. Sex ☐ Male ☐ Female

20. Social Security number (SSN) - -

We need this if you want health coverage and have an SSN. We use SSNs to check income and other information to see if you're eligible for help with health coverage costs. If you need help getting an SSN, call 1-800-772-1213 or visit **socialsecurity.gov**. TTY users should call 711.

21. Are you a U.S. citizen or U.S. national? ☐ Yes ☐ No

22. **If you aren't a U.S. citizen or U.S. national,** do you have eligible immigration status? *(See instructions.)*

☐ Yes. Fill in your document type and ID number below.

a. Immigration document type: ____________________

b. Document ID number

c. Have you lived in the U.S. since 1996? ☐ Yes ☐ No

d. Are you a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

23. Are you pregnant? ☐ Yes ☐ No a. If **yes,** how many babies are expected during this pregnancy?

24. Do you have a physical, mental, or emotional health condition that causes limitations in daily activities (like bathing, dressing, daily chores, etc.) or live in a medical facility or nursing home? ☐ Yes ☐ No

25. **If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)**

☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other ____________

26. **Race (OPTIONAL—check all that apply.)**

☐ White
☐ Black or African American
☐ American Indian or Alaska Native
☐ Asian Indian
☐ Chinese
☐ Filipino
☐ Japanese
☐ Korean
☐ Vietnamese
☐ Other Asian
☐ Native Hawaiian
☐ Guamanian or Chamorro
☐ Samoan
☐ Other Pacific Islander
☐ Other ____________

STEP 2 Current Job & Income Information

☐ **Employed:** If you're currently employed, tell us about your income. Start with question 1.

☐ **Not employed:** Skip to question 11.

☐ **Self-employed:** Skip to question 10.

CURRENT JOB 1:

1. Employer name

a. Employer address

b. City | c. State | d. ZIP code | 2. Employer phone number ( ) –

3. Wages/tips (before taxes) $ ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

4. Average hours worked each WEEK

CURRENT JOB 2: (If you have more jobs and need more space, attach another sheet of paper.)

5. Employer name

a. Employer address

b. City | c. State | d. ZIP code | 6. Employer phone number ( ) –

7. Wages/tips (before taxes) $ ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

8. Average hours worked each WEEK

9. **In the past year, did you:** ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

10. **If self-employed, answer the following questions:**
   a. Type of work: ____________________
   b. How much net income (profits once business expenses are paid) will you get from this self-employment this month? *(See instructions.)* $

11. **OTHER INCOME THIS MONTH:** Check all that apply and give the amount and how often you get it.

NOTE: You don't need to tell us about child support, veteran's payment, or Supplemental Security Income (SSN)

☐ None

☐ Unemployment $ How often?__________

☐ Pension $ How often?__________

☐ Social Security $ How often?__________

☐ Retirement accounts $ How often? __________

☐ Alimony received $ How often? __________

☐ Net farming/fishing $ How often? __________

☐ Other income Type: ____________ $ How often? __________

12. Do you pay student loan interest (not the amount of the loan) or alimony that can be deducted on a federal income tax return?

☐ **YES, STUDENT LOAN INTEREST** $ How often?___________ ☐ **YES, ALIMONY** $ How often?______

13. **YEARLY INCOME: Complete only if your income changes from month to month. If you don't expect changes to your monthly income, skip to Step 3.**

Your total income **this year** $

Your total income **next** year (if you think it will be different) $

Step 3 Your Health Coverage

1. **Are you enrolled in health coverage now from the following?**

☐ YES. **If yes**, check which coverage you have. ☐ NO.

☐ Medicaid
☐ CHIP
☐ Medicare
☐ TRICARE (Don't check if you have Direct Care or Line of Duty)
☐ Peace Corps
☐ VA health care program
☐ Other
Name of health insurance:
Policy number:

2. **Application for Premium Reductions:** Do you want to apply for monthly premiums reductions, lower out-of-pocket costs, and see if you qualify for Medicaid (MaineCare) or CubCare (CHIP)? ☐ Yes ☐ No

(If you answered "NO" to question 2, please skip to section 4: Read & Sign This Application)

3. **Taxes:** Will you file taxes in 2021? ☐ Yes ☐ No If yes, are you filing taxes either ☐ jointly or as the ☐ head of household?

4. **Tax Dependent:** Will you be claimed as a tax dependent in 2021? ☐ Yes ☐ No

5. **Health Reimbursement Arrangement**: Are you currently getting help paying for health coverage through a Health Reimbursement Arrangement? ☐ Yes ☐ No

6. **Another Person's Health Reimbursement Arrangement**: Do you currently have access to a Health Reimbursement Arrangement you are not currently enrolled in (like through a parent or spouse)? ☐ Yes ☐ No

7. **Previous MaineCare or CubCare Determination**: Were you found not eligible for MaineCare or CubCare within the last 90 days?

☐ Yes ☐ No

If yes, when were you denied coverage? ___________________________

If no, do you have MaineCare or CubCare that will end soon or that recently ended because of a change in eligibility? ☐ Yes ☐ No

8. **Other Questions:**

a. Are you currently pregnant? ☐ Yes ☐ No If so, what is your due date? ____________________________

b. Were you pregnant within the last 60 days? ☐ Yes ☐ No If so, what was your due date? ______________________

   a. If you were pregnant within the last 60 days, were you enrolled in Medicaid during the pregnancy? ☐ Yes ☐ No

c. Were you in foster care at age 18 or older? ☐ Yes ☐ No

   a. If you were in foster care at age 18 or older, what state were you in foster care? _______________________

   b. If you were in foster care at age 18 or older, how old were you when you left foster care? __________

d. Are you a full-time student? ☐ Yes ☐ No

e. Are you visually impaired? ☐ Yes ☐ No

f. Do you need help with daily life activities, such as dressing or bathing? ☐ Yes ☐ No

g. Do you need any help paying for medical bills from the past 3 months? ☐ Yes ☐ No

h. Are you living with a disability? ☐ Yes ☐ No

i. Are you the main person taking care of any children age 18 or younger? ☐ Yes ☐ No

j. Do you use tobacco? ☐ Yes ☐ No

Step 4 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 **CoverME.gov** if anything changes (and is different than) what I wrote on this application. I can visit **CoverME.gov** or call 1-866-636-0355. to report any changes. I understand that a change in my information could affect my eligibility.
- 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 **www.hhs.gov/ocr/office/file**.
- I know that my information on this form will be used only to determine eligibility for health coverage and will be kept private as required by law.
- I confirm that I'm not incarcerated (detained or jailed).
- I confirm that next year I expect to file a federal income tax return, won't claim dependents on that return, and can't be claimed as a dependent on another federal income tax return.
- I confirm that I'm not offered health coverage from an employer.

We need this information to check your eligibility for help paying for health coverage if you choose to apply. We'll check your answers using information in our electronic databases and databases from the Internal Revenue Service (IRS), Social Security, the Department of Homeland Security, and/or a consumer reporting agency. If the information doesn't match, we may ask you to send us proof.

Renewal of coverage in future years

To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow **CoverME.gov** to view income data, including information from tax returns. CoverME.gov will send me a notice and let me make any changes, and I can opt out at any time.

Yes, renew my eligibility automatically for the next

☐ 5 years (the maximum number of years allowed), or for a shorter number of years:
☐ 4 years ☐ 3 years ☐ 2 years ☐ 1 year
☐ Don't use information from tax returns to renew my coverage.

If I'm eligible for Medicaid

If I enroll in Medicaid, I'm giving the Medicaid agency my rights to pursue and get any money from other health insurance, settlements, or other third parties.

What should I do if I think my eligibility results are wrong?

If you don't agree with what you qualify for, in many cases, you can ask for an appeal. Please review your eligibility notice to find appeals instructions specific to each person in your household, including how many days you have to request an appeal. Below is important information to consider when requesting an appeal:

- You can have someone request or participate in your appeal if you want to. That person can be a friend, relative, lawyer, or other individual. Or, you can request and participate in your appeal on your own.
- If you request an appeal, you may be able to keep your eligibility for coverage while your appeal is pending.
- The outcome of an appeal could change the eligibility of other members of your household.

To appeal your eligibility results, complete and return the Appeal Request Form available on **CoverME.gov**. You can appeal eligibility for purchasing health coverage through **CoverME.gov**, enrollment periods, tax credits, cost- sharing reductions, or Medicaid, if you were denied these. If you qualify for tax credits or cost-sharing reductions, you can appeal the amount we determined you are eligible for.

Sign this application. The person who filled out Step 1 should sign this application. If you're an authorized representative, you may sign here as long as you've provided the information required in Appendix A.

Signature	Date (mm/dd/yyyy)
	__ __ / __ __ / __ __ __ __

Step 5 Mail Completed Application

Mail your signed application to:

CoverME.gov Consumer Assistance Center
P.O. Box 616
Augusta, ME 04332-6626

Use blue or black ink to complete this application.

STEP 1 Tell us about yourself (Non-Primary Applicant)

CHECK THIS BOX IF YOU ARE NOT APPLYING FOR COVERAGE ☐

1. First name | Middle name | Last name | Suffix

2. Home address (☐ Check this box if you live with Person 1. If so, skip to Question 18.)
3. Apartment or suite number
4. City
5. State
6. ZIP code
7. County (optional)
8. Mailing address (if different from home address)
9. Apartment or suite number
10. City
11. State
12. ZIP code
13. County
14. Phone number ( ) –
15. Other phone number ( ) –
16. Do you want to get information about this application by email? ☐ Yes ☐ No

Email address: ____________________

17. What is your preferred spoken or written language (if not English)?
18. Date of birth (mm/dd/yyyy) / /
19. Sex ☐ Male ☐ Female
20. Social Security number (SSN) - -

If you do not have an SSN, check this box ☐.

We need this if you want health coverage and have an SSN. We use SSNs to check income and other information to see if you're eligible for help with health coverage costs. If you need help getting an SSN, call 1-800-772-1213 or visit **socialsecurity.gov**. TTY users should call 711.

21. Are you a U.S. citizen or U.S. national? ☐ Yes ☐ No
22. **If you aren't a U.S. citizen or U.S. national,** do you have eligible immigration status? *(See instructions.)*

☐ Yes. Fill in your document type and ID number below.

a. Immigration document type: ____________________

b. Document ID number

c. Have you lived in the U.S. since 1996? ☐ Yes ☐ No

d. Are you a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

23. Are you pregnant? ☐ Yes ☐ No a. If **yes,** how many babies are expected during this pregnancy? ☐
24. Do you have a physical, mental, or emotional health condition that causes limitations in daily activities (like bathing, dressing, daily chores, etc.) or live in a medical facility or nursing home? ☐ Yes ☐ No
25. **If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)**

☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other ____________

26. **Race (OPTIONAL—check all that apply.)**

☐ White
☐ Black or African American
☐ American Indian or Alaska Native
☐ Asian Indian
☐ Chinese
☐ Filipino
☐ Japanese
☐ Korean
☐ Vietnamese
☐ Other Asian
☐ Native Hawaiian
☐ Guamanian or Chamorro
☐ Samoan
☐ Other Pacific Islander
☐ Other ____________

27. What is this person's relationship to the Primary Applicant? ____________________

STEP 2 Current Job & Income Information

☐ **Employed:** If you're currently employed, tell us about your income. Start with question 1.

☐ **Not employed:** Skip to question 11.

☐ **Self-employed:** Skip to question 10.

CURRENT JOB 1:

1. Employer name

a. Employer address

b. City	c. State	d. ZIP code	2. Employer phone number
			( ) –

3. Wages/tips (before taxes) $ ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

4. Average hours worked each WEEK

CURRENT JOB 2: (If you have more jobs and need more space, attach another sheet of paper.)

5. Employer name

a. Employer address

b. City	c. State	d. ZIP code	6. Employer phone number
			( ) –

7. Wages/tips (before taxes) $ ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

8. Average hours worked each WEEK

9. **In the past year, did you:** ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

10. **If self-employed, answer the following questions:**
   a. Type of work: ______________________________
   b. How much net income (profits once business expenses are paid) will you get from this self-employment this month? *(See instructions.)* $

11. **OTHER INCOME THIS MONTH:** Check all that apply and give the amount and how often you get it.

NOTE: You don't need to tell us about child support, veteran's payment, or Supplemental Security Income (SSN).

☐ None			☐ Retirement accounts	$	How often? ________
☐ Unemployment	$	How often?________	☐ Alimony received	$	How often? ________
☐ Pension	$	How often?________	☐ Net farming/fishing	$	How often? ________
☐ Social Security	$	How often?________	☐ Other income Type: __________	$	How often? ________

12. Do you pay student loan interest (not the amount of the loan) or alimony that can be deducted on a federal income tax return?

☐ **YES, STUDENT LOAN INTEREST** $ How often?________ **YES, ALIMONY** $ How often? ______

13. **YEARLY INCOME: Complete only if your income changes from month to month. If you don't expect changes to your monthly income, skip to Step 3.**

Your total income **this year**	Your total income **next** year (if you think it will be different)
$	$

Step 3 Your Health Coverage

1. **Are you enrolled in health coverage now from the following?**

☐ YES. **If yes**, check which coverage you have... ☐ NO.

- ☐ Medicaid
- ☐ CHIP
- ☐ Medicare
- ☐ TRICARE (Don't check if you have Direct Care or Line of Duty)
- ☐ Peace Corps
- ☐ VA health care program
- ☐ Other

Name of health insurance:

Policy number:

2. **Application for Premium Reductions:** Do you want to apply for monthly premiums reductions, lower out-of-pocket costs, and see if you qualify for Medicaid (MaineCare) or CubCare (CHIP)? ☐ Yes ☐ No

(If you answered "NO" to question 2, please skip to section 4: Read & Sign This Application)

3. **Taxes:** Will you file taxes in 2021? ☐ Yes ☐ No

4. **Tax Dependent:** Will you be claimed as a tax dependent in 2021? ☐ Yes ☐ No

5. **Health Reimbursement Arrangement**: Are you currently getting help paying for health coverage through a Health Reimbursement Arrangement? ☐ Yes ☐ No

6. **Another Person's Health Reimbursement Arrangement**: Do you currently have access to a Health Reimbursement Arrangement you are not currently enrolled in (like through a parent or spouse)? ☐ Yes ☐ No

7. **Previous MaineCare or CubCare Determination**: Were you found not eligible for MaineCare or CubCare within the last 90 days? ☐ Yes ☐ No

If yes, when were you denied coverage? ________________________

If no, do you have MaineCare or CubCare that will end soon or that recently ended because of a change in eligibility? ☐ Yes ☐ No

8. **Other Questions:**

   a. Are you currently pregnant? ☐ Yes ☐ No If so, what is your due date?

   b. Were you pregnant within the last 60 days? ☐ Yes ☐ No If so, what was your due date?

      a. If you were pregnant within the last 60 days, were you enrolled in Medicaid during the pregnancy? ☐ Yes ☐ No

   c. Were you in foster care at age 18 or older? ☐ Yes ☐ No

      a. If you were in foster care at age 18 or older, what state were you in foster care?

      b. If you were in foster care at age 18 or older, how old were you when you left foster care?

   d. Are you a full-time student? ☐ Yes ☐ No

   e. Are you visually impaired? ☐ Yes ☐ No

   f. Do you need help with daily life activities, such as dressing or bathing? ☐ Yes ☐ No

   g. Do you need any help paying for medical bills from the past 3 months? ☐ Yes ☐ No

   h. Are you living with a disability? ☐ Yes ☐ No

   i. Are you the main person taking care of any children age 18 or younger? ☐ Yes ☐ No

   j. Do you use tobacco? ☐ Yes ☐ No

APPENDIX A

Form Approved
OMB No. 0938-1191

Assistance with completing this application

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."

My authorized representative's authority is limited to the task or tasks I have delegated, above. This appointment is valid until:

- I change this appointment in writing by notifying CoverME.gov that this Authorized Representative is no longer authorized to act on my behalf; or My Authorized Representative informs the CoverME.gov in writing that he/she is no longer acting as my Authorized Representative.
- I understand that taking back this appointment does not apply to any documents signed by or sent to my Authorized Representative before I took back the appointment.

1. Name of authorized representative (First name, Middle name, Last name)

2. Address

3. Apartment or suite number

4. City

5. State

6. ZIP code

7. Phone number

( ) –

8. Authorized Representative's Email Address (if applicable)

By signing, you allow this person to sign your application, get official information about this application, and act for you on all future matters related to this application. I am signing this form voluntarily, and I have the right to a signed copy of this form if I request one.

If your appointed authorized representative is legally appointed for someone on this application, submit proof with the application.

9. Your signature

10. Date (mm/dd/yyyy)

/ /

WANT TO REGISTER TO VOTE? APPLYING TO REGISTER OR DECLINING TO REGISTER TO VOTE WILL NOT AFFECT THE AMOUNT OF ASSISTANCE THAT YOU WILL BE PROVIDED BY COVERME.GOV.

MAINE VOTER REGISTRATION APPLICATION

Federally required questions:

- **Are you a citizen of the United States of America?*** ❑ YES ❑ NO
  *If NO, DO NOT complete this application.
- **Are you at least 18 years of age?**** ❑ YES ❑ NO
  **If NO, but you are at least 16 years of age, you may pre-register to vote.

PARTY AFFILIATION

❑ Democratic
❑ Green Independent
❑ Republican
❑ Other qualifying party: ____________________
❑ Unenrolled (no party choice)

LAST NAME	FIRST NAME	MIDDLE NAME	DATE OF BIRTH
			__ __/__ __/__ __ __ __ MM DD YYYY

CURRENT RESIDENCE ADDRESS (Physical address where you live)

STREET NAME AND NUMBER, <u>NOT</u> A P.O. BOX	CITY, TOWN, PLANTATION OR TOWNSHIP

CURRENT MAILING ADDRESS (Complete if different from above address)

STREET NAME AND NUMBER, OR P.O. BOX, etc.	CITY/TOWN	ZIP CODE

Have you previously been registered to vote? ❑ YES ❑ NO
If the answer is "yes" provide address of previous registration below.

CITY/TOWN	COUNTY	STATE	TELEPHONE (Optional)

COMPLETE BOTH SIDES OF THIS CARD – PLEASE PRINT

MAINE VOTER REGISTRATION APPLICATION

- COMPLETE BOTH SIDES OF THIS CARD -

CHANGE OF NAME (Prior legal name, if applicable)

____
LAST FIRST MIDDLE

SIGN AND DATE THIS CARD. I certify that all the information I have provided on this form is true.

____
Signature of Applicant on line above **Date on line above**

VOTER ID: By federal law, <u>NEW</u> <u>Maine</u> <u>voters</u> <u>must</u> provide an applicable ID number as follows:

1. Your <u>Maine</u> driver's license/<u>Maine</u> State ID; or
2. The last 4 digits of your Social Security number (ONLY if you don't have a <u>Maine</u> driver's license/ <u>Maine</u> State ID); or
3. Write "none" ONLY if you don't have either 1 or 2.

___ | ___ | ___ | ___ | ___ | ___ | ___

<u>REGISTRAR'S USE ONLY:</u> **Date Received**: ________________ **Ward-Precinct**: ________ - ________

Source of Registration: ❑ In Person ❑ By Mail ❑ Agency ❑ BMV ❑ Voter Registration Drive/3rd Person

Type of Registration:

❑ **<u>NEW</u>** <u>Maine Voter Registration</u> **Form of Proof for ID:** ______________ **for Residency**: ________________

❑ **<u>Change</u>** <u>of Existing Voter Registration</u> (*check boxes below*) **Form of Proof for Residency:** ________________

❑ Address Change to new municipality ❑ Address Change within municipality ❑ Party Enrollment Change
❑ Name Change ❑ Other Change ______________________

❑ **<u>Duplicate</u>** <u>Application</u> (no changes made)

<u>INSTRUCTIONS TO VOTERS:</u> Failure to complete this entire application may prevent registration.

- Deliver or mail this completed card to your municipal registrar or to the Division of Elections: #101 State House Station, Augusta, ME 04333-0101. This properly completed application must be received by the municipal registrar 21 days or more before an election. <u>If less than 21 days before an election, you must register in person</u>.
- **<u>If you are a NEW Maine voter and mail this card</u>**, you must include a photocopy of your Maine driver's license, Maine State ID, or current utility bill, bank statement or government document that shows your name and address.
- For election information, call 207-624-7650 or visit <u>www.maine.gov/sos/cec/elec/</u> **(rev. 1/20)**

If you fill out the voter registration application, please deliver or mail this section separate from your CoverME.gov application to your municipal registrar or the Division of Elections at 101 State House Station, Augusta, ME 04333-0101.

coverME.gov
AFFORDABLE HEALTH COVERAGE FOR MAINE

Permission for information submitted

By submitting this application, you represent that you have permission from all of the people whose information is on the application to both submit their information to the Marketplace and receive any communications about their eligibility and enrollment.

Privacy Act Statement (effective 11/01/2021)

We are authorized to collect the information on this form and any supporting documentation, including social security numbers, under the Patient Protection and Affordable Care Act (Public Law No. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law No. 111-152), and the Social Security Act.

We need the information provided about you and the other individuals listed on this form to determine eligibility for: (1) enrollment in a qualified health plan through CoverME.gov, (2) insurance affordability programs (such as Medicaid, advanced payment of the premium tax credits, and cost sharing reductions), and (3) certifications of exemption from the individual responsibility requirement. As part of that process, we will verify the information provided on the form, communicate with you or your authorized representative, and eventually provide the information to the health plan you select so that they can enroll any eligible individuals in a qualified health plan or insurance affordability program. We will also use the information provided as part of the ongoing operation of CoverME.gov, including activities such as verifying continued eligibility for all programs, processing appeals, reporting on and managing the insurance affordability programs for eligible individuals, performing oversight and quality control activities, combatting fraud, and responding to any concerns about the security or confidentiality of the information.

While providing the requested information (including social security numbers) is voluntary, failing to provide it may delay or prevent your ability to obtain health coverage through CoverME.gov, advanced payment of the premium tax credits, cost sharing reductions, or an exemption from the shared responsibility payment. If you don’t have an exemption from the shared responsibility payment and you don’t maintain qualifying health coverage for three months or longer during the year, you may be subject to a penalty. If you don’t provide correct information on this form or knowingly and willfully provide false or fraudulent information, you may be subject to a penalty and other law enforcement action.

In order to verify and process applications, determine eligibility, and operate, we will need to share selected information that we receive outside of CoverME.gov, including to:

1. Federal agencies, (such as the Internal Revenue Service, Social Security Administration and Department of Homeland Security), or local government agencies. We may use the information you provide in computer matching programs with any of these groups to make eligibility determinations, to verify continued eligibility for enrollment in a qualified health plan or Federal benefit programs, or to process appeals of eligibility determinations;
2. Other verification sources including consumer reporting agencies;
3. Employers identified on applications for eligibility determinations;
4. Applicants/enrollees, and authorized representatives of applicants/enrollees;
5. Agents, Brokers, and issuers of Qualified Health Plans, as applicable, who are certified by CoverME.gov who assist applicants/enrollees;
6. Contractors engaged to perform a function for CoverME.gov; and
7. Anyone else as required by law.

This statement provides the notice required by the Privacy Act of 1974 (5 U.S.C. § 552a(e)(4)).

Get Help In Your Language

This notice has important information. This notice has important information about your application or coverage through CoverME.gov. Look for key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call (866) 636-0355 TTY: 711.

Cet avis contient des informations importantes. Cet avis contient des informations importantes au sujet de votre demande ou de la couverture par CoverME.gov. Cherchez les dates clés dans cet avis. Vous devrez peut-être prendre des mesures en respectant certaines échéances afin de maintenir votre couverture de santé ou d'assumer des coûts. Vous avez le droit d'obtenir ces informations et d'être aidé dans votre langue sans frais. Appelez le (866) 636-0355 TTY: 711.

Este aviso contiene información importante. Este aviso contiene información importante acerca de su solicitud o su seguro con CoverME.gov. Preste atención a las fechas que aparecen en este aviso, puesto que podría ser necesaria alguna acción por su parte antes de determinada fecha a fin de mantener su seguro médico con nosotros o sus ayudas con el coste. Usted tiene derecho a recibir esta información y soporte en su idioma sin coste adicional. Llame al (866) 636-0355 TTY: 711.

本通知包含重要信息。本通知包含有关您通过 CoverME.gov 提交申请和保险的重要信息。请查看本通知中的关键日期。您可能需要在特定截止日期前采取行动，以便维持您的健康保险或有助于降低费用。您有权免费以自己的母语获得本信息和帮助。请致电 (866) 636-0355 TTY: 711。

Ogaysiiskaan waxaa ku jira xog muhiim ah. Ogaysiiskaan waxaa ku jira xog muhiim ah oo ku saabsan codsigaaga ama caymiska aad ka helayso CoverME.gov. Ka fiiri taariikhaha muhiimka ah ogaysiiskaan. Waxaad u baahan kartaa inaad qaado talaabo xiliyo gaar ah si aad u hesho caymiskaaga caafimaadka ama lagaaga caawiyo qarashaadka. Waxaad xaq u leedahay inaad hesho xog iyo caawimaad ku baxaysa luuqadaada si bilaash ah, wac (866) 636-0355 TTY: 711.

يحوي هذا الاشعار معلومات هامة. يحوي هذا الاشعار معلومات هامة بخصوص طلبك أو تغطيتك من خلال CoverME.gov. ابحث عن التواريخ الهامة في هذا الاشعار. قد تحتاج لاتخاذ اجراء في تواريخ معينة للحفاظ على تغطيتك الصحية او للمساعدة في دفع التكاليف. لك الحق في الحصول على هذه المعلومات والمساعدة بلغتك من دون أي تكلفة. اتصل بـ (866) 636-0355 TTY: 711.

Ilani hii ina habari muhimu. Ilani hii ina habari muhimu kuhusu ombi lako au bima yako ya afya ya CoverME.gov. Angalia tarehe muhimu katika ilani hii. Unaweza kuhitaji kuchukua hatua kwa muda uliowekwa ili kudumisha bima yako ya afya au kusaidia kwa gharama. Una haki ya kupata habari hii na usaidizi katika lugha yako bila malipo. Piga simu (866) 636-0355 TTY: 711.

Libihne lini li gwe banga bi niigana. Libihne lini li gwe banga bi niigana kolbaha ni ndjombi yoŋ tole ma teeda moŋ loŋ ni CoverME.gov. Yeŋ ma kel ma tobo tobo munu libihne lini. Bebeg le u ga bana nguim mam i boŋ nwaa le guim di loo di kola i nyu I teda mateda tole nsaa u mboo woŋ. U gwee kundei kosna biniguene bini ni mahola ni hop wong ngui nsaa wogui wo. Sebel I nsinga ini (866) 636-0355 TTY: 711.

Iri tangazo ririmwo inkuru ikomeye. Iri tangazo ririmwo inkuru ikomeye ijanye n'ivyo wasavye canke n'ubwishingizi mu kwivuza uciye aho bita CoverME.gov. Raba amatariki nyamukuru muri iri tangazo. Urashobora gusanga ari ngombwa ko ufata ingingo imbere y'amatariki ntarengwa kanaka kugira ntutakaze ubwishingizi mu kwivuza bwawe canke kugira bigufashe mu bijanye n'ibiciro. Urafise uburenganzira bwo kuronka aya makuru hamwe n'ubufasha mu rurimi rwawe ku buntu. Hamagara <nimero ya terefone y'Akaguriro (866) 636-0355 TTY: 711.

សេចក្តី ជូន ដំណឹង នេះមានព័ត៌មាន សំខាន់ ។ សេចក្តី ជូនដំណឹង នេះ មានព័ត៌មាន សំខាន់ អំពីពាក្យសុំ ឬការ ធានា រ៉ាប់ រងរបស់អ្នក តាមរយៈ CoverME.gov ។ សូម រកមើល កាលបរិច្ឆេទ សំខាន់ៗក្នុង សេចក្តី ជូនដំណឹងនេះ ។ អ្នកត្រូវ ចាត់ ចែងកិច្ចការពាក់ព័ន្ធ ឲ្យ

បានទៅតាមកាលកំណត់នានា ដើម្បីរក្សាបាន នូវការ ធានារ៉ាប់រង ឬរក្សាបានជំនួយក្នុងការ
ចេញថ្លៃចំណាយនានា ។ អ្នក មានសិទ្ធិ ទទួលបាន ព័ត៌មាន នេះ និងទទួលបានការជួយដោយប្រើ ភាសា
របស់អ្នក ដោយមិន អស់ប្រាក់ ។ សូម ហៅ ទូរស័ព្ទ មកលេខ (866) 636-0355 TTY: 711 ។

Thông báo này có Thông tin Quan trọng. Thông báo này có thông tin quan trọng về đơn hoặc hợp đồng bảo hiểm của bạn qua CoverME.gov. Xin xem những ngày quan trọng trong thông báo này. Quý vị có thể phải thực hiện theo đúng thời hạn để duy trì bảo hiểm sức khỏe hoặc giúp đỡ chi phí. Quý vị có quyền được biết thông tin này và được trợ giúp bằng ngôn ngữ của mình miễn phí. Xin gọi số (866) 636-0355 TTY: 711.

Este aviso contém informações importantes. Este aviso contém informações importantes sobre o seu pedido ou cobertura através da CoverME.gov. Procure as datas chave neste aviso. Poderá necessitar de tomar providências dentro de certos prazos para manter a sua cobertura de saúde ou para obter ajuda com custos. Tem o direito de obter estas informações e ajuda no seu idioma sem qualquer custo. Ligue (866) 636-0355 TTY: 711.

Die Nachricht enthält wichtige Informationen bezüglich Ihres Antrags bei oder Ihres Versicherungsschutzes durch CoverME.gov. Suchen Sie nach Schlüsseldaten in dieser Nachricht. Sie müssen eventuell vor einer bestimmten Frist reagieren, um Ihren Versicherungsschutz aufrechtzuerhalten oder um Hilfe bezüglich der Kosten zu erhalten. Sie haben das Recht, diese Information und Hilfe kostenfrei in Ihrer Sprache zu erhalten. Wählen Sie hierfür (866) 636-0355 TTY: 711.

May Importanteng Impormasyon ang abisong ito. May Importanteng Impormasyon ang abisong ito tungkol sa aplikasyon mo o proteksiyon mo sa CoverME.gov. Tingnan ang mga importanteng petsa na nasa abisong ito. Maaaring may mga kailangan kang gawin bago sumapit ang ilang deadline para mapanatili ang proteksiyon mo sa kalusugan o para makatulong sa mga gastusin. Karapatan mong makuha ang impormasyon na ito at makakuha ng tulong na nasa wika mo nang walang gastos. Tumawag sa (866) 636-0355 TTY: 711.

ใบประกาศนี้มีข้อมูลสำคัญ ใบประกาศนี้มีข้อมูลที่สำคัญเกี่ยวกับการสมัครหรือขอบเขตประกันสุขภาพของคุณกับ CoverME.gov โปรดดูกำหนดการในใบประกาศนี้ให้ดี
คุณอาจจะต้องดาเนินการภายในกำหนดระยะเวลาที่แน่นอนเพื่อที่จะรักษาการประกันสุขภาพของคุณหรือการขอร้องความช่วยเหลือกับค่าใช้จ่าย คุณมีสิทธิที่จะได้รับข้อมูลและความช่วยเหลือเกี่ยวกับเรื่องนี้ในภาษาของคุณโดยไม่ต้องเสียอะไร โทร (866) 636-0355 TTY: 711

В этом уведомлении содержится важная информация. В этом уведомлении содержится важная информация о вашем заявлении или страховом покрытии, предоставляемом через интернет-платформу CoverME.gov. Обратите внимание на ключевые даты, указанные в данном уведомлении. Возможно, вам будет необходимо предпринять определенные шаги до указанного предельного срока, чтобы сохранить своё страховое покрытие или получить помощь в оплате расходов. У вас есть право на получение данной информации и предоставление бесплатной помощи переводчика. Звоните (866) 636-0355 TTY: 711.