

Application for Health Coverage & Help Paying Costs

➔ Apply faster online at getcovered.nj.gov



Use this application to see what coverage you qualify for

- Marketplace plans that offer comprehensive coverage, including pre-existing conditions.
- Financial help that can immediately help lower your premiums for health coverage.
- Free or low-cost coverage through Medicaid or the Children's Health Insurance Program (CHIP).



Who can use this application?

- Use this application to apply for anyone in your household.
- Apply even if you, your spouse, or your child already have health coverage. You could be eligible for financial help.
- Households that include eligible immigrants can apply. You can apply for your child even if you are not eligible for coverage. Applying will not affect your immigration status or chances of becoming a permanent resident or citizen.



What you may need to apply

- Social Security Numbers (SSNs) (or document numbers for any eligible immigrants who need coverage).
- Employer and income information for everyone in your household (like from pay stubs, W-2 forms, or wage and tax statements).
- Policy numbers for any current health insurance.
- Information about any job-related health insurance available to your household.



What happens next?

- Print a blank form to fill in by hand using black or dark blue ink.
- Sign the completed form and mail together with any supporting documents to:

Get Covered New Jersey
Attn: Application
PO Box 55898
Trenton, NJ 08638



Get help with this application

- **Online:** getcovered.nj.gov.
- **Phone:** Call the GetCoveredNJ Call Center at **1-833-677-1010**. TTY users can call **711**.
- **In-person:** There may be counselors in your area who can help. Visit getcovered.nj.gov, or call the GetCoveredNJ Call Center at **1-833-677-1010** for more information.
- **En Español:** Llame a nuestro centro de ayuda gratis al **1-833-677-1010**.
- **Other languages:** If you need help in a language other than English, call 1-833-677-1010 and tell the customer service representative the language you need. We'll get you help at no cost to you.

Before we Begin:

Privacy & Use of Information

Protecting your personal information is important to Get Covered New Jersey and we will keep your information private as required by law. Your answers on this application will only be used to determine eligibility for health coverage. We will check your answers using the information in our electronic database and the databases of other state and federal agencies. If the information does not match, we may ask you to send us proof.

We will not ask any questions about your medical history. Household members who do not want coverage will not be asked questions about citizenship or immigration status.

Important:

As part of the GetCoveredNJ application process, we may disclose and retrieve your information through secure electronic data exchanges with the Internal Revenue Service (IRS), Social Security Administration (SSA), the Department of Homeland Security (DHS), or a consumer reporting agency (such as Equifax). These data exchanges are authorized by the Affordable Care Act. We need this information to verify your identity, income and other information on your application to determine if you are eligible for health coverage and financial help through GetCoveredNJ. We may also check your information at a later time to make sure your program eligibility is up to date.

We also communicate with you or your designated representative and we provide the information to the health insurance company you select so that it can enroll you in your health plan. If you choose to use a designated representative, such as a health insurance agent or an enrollment assister, they will be able to see your application information.

Information in this application may also be shared with NJ FamilyCare's Medicaid and Children's Health Insurance Program. NJ FamilyCare will keep your information private as required by law. Your answers on this application and any additional information you provide to NJ FamilyCare will be used for determination of eligibility for its programs, to verify identity and financial information such as income and bank account information, to determine the amount of medical assistance or coverage, to provide benefits, to pay for benefits, and to prevent duplicate or incorrectly paid benefits, and for recovery purposes.

The Privacy Policy can be accessed at any time at www.getcovered.nj.gov under "Privacy." You can request a paper copy by calling 1-833-677-1010 and providing your mailing address. The NJ FamilyCare Rights and Responsibilities, Privacy Policy, and Notice of Privacy Practices can be accessed at any time at <http://www.njfamilycare.org/links.aspx> under "Helpful Links." You can request a paper copy by calling 1-800-356-1561.

I consent to have my information sent, retrieved and used as outlined above for all of the individuals that will be included on my application. I have reviewed the State of New Jersey's Privacy Policies listed above and understand that it these police apply to GetCoveredNJ and NJ FamilvCare.

All fields on this application marked with an asterisk (*) are required unless otherwise marked.

Please print in Capital letters using black or dark blue ink only. Clearly mark or fill in squares to indicate your answer.

Send in only COPIES of all official documentation

Documents to Provide to Prove Identity:

* Your enrollment cannot be completed until all **NECESSARY** items are received. Free help is available if needed. You can find local help on the GetCoveredNJ website under "We Can Help" and "Find Local Assistance:" at www.getcovered.nj.gov, or you can call 1-833-677-1010. **YOU DO NOT NEED TO SEND ALL DOCUMENTS.** GetCoveredNJ only needs documents that apply to you or others who are applying. Do not send original documents—please send copies only.

You need to provide proof of Identity, U.S. Citizenship and/or Immigration Status and Date of Birth.

You can provide **ONE** of the following documents (copy only) to prove both U.S. Citizenship, Identity and your Date of Birth:

- U.S. passport book/card, OR
- Certificate of Naturalization (DHS Forms N-550 or N-570), OR
- Certificate of U.S. Citizenship (DHS Forms N-560 or N-561), OR
- NJ Real ID Enhanced Driver's License.

When one of the above documents is not available, **ONE** document from **EACH** of the lists below may be used to prove your citizenship and/or identity (copies only, no originals). This list is not all-inclusive. If you do not have one of these documents, you can find local help with your application on the GetCoveredNJ website under "We Can Help" and "Find Local Assistance:" at www.getcovered.nj.gov, or you can call 1-833-677-1010.

Documents with * next to it also show date of birth

U.S. Citizenship

- U.S. Birth Certificate*
- Certification of Birth issued by Department of State (Forms FS-545 or DS-1350) *
- Report of Birth Abroad (FS-240)
- U.S. National ID card (Form I-197 or I-179)
- Native American Tribal Document*
- Religious/School Records*

Identity

- State Driver's license or ID card with photo*
- ID card issued by a federal, state, or local government agency
- U.S. Military card or draft record or U.S Coast Guard Merchant Mariner Card
- School ID card with a photo (may also show date of birth)
- Certificate of Degree of Indian blood or other Native American/Alaska Native tribal document with photo

- Military record of service showing U.S. place of birth
- Final adoption decree
- Evidence of qualifying for U.S. citizenship under the Child Citizenship Act of 2000

- Verified School, Nursery or Daycare records (for children under 18) (may also show date of birth)
- Clinic, Doctor or Hospital records (for children under 18) *

I. Primary Contact Information:

First Name*		Middle Name		Last Name*	
Suffix					
Date of Birth (xx/xx/xxxx):			Email:		
			<input type="checkbox"/> Send me important alerts to this email address		
Home address (Leave blank only if you don't have one.) *				Home Address 2	
Enter address here				Address 2 here	
City*		State*	Zip Code*	County*	

Primary Contact Mailing Address

Check if same as Primary Contact Home Address

If not the same, fill out Primary Contact Home Address Below. If Yes, please jump to Phone Number

Primary Contact Home address (Leave blank if you don't have one.) *			Home Address 2		
City*		State*	Zip Code*	County*	
Mobile Phone Number		Home Phone Number		Phone Extension	
<input type="checkbox"/> Send me important alerts to this phone number. Standard message rates may apply					

Primary Contact Preference:

Preferred Spoken Language (please fill in):

Preferred Written Language (please fill in):

Preferred Method of Communication* Go Paperless Postal Mail

How do you wish to receive your 1095-A form* Go Paperless Postal Mail

II. Help Applying for Coverage:

Is anyone Helping you with this application? *

- Someone is helping Me
- I am filling out this application for myself and/or my family

If you do not currently have assistance and would like assistance, please go to getcovered.nj.gov

If someone is helping, fill out the following information. IF NOT, go to Section III “Help Paying for Coverage.”

Authorized Representative

If someone is helping you complete your application, you can designate that person as your Authorized Representative.

An Authorized Representative is any adult who is sufficiently aware of the household circumstances and is authorized by the household to act on behalf of the household for eligibility purposes. By designating an Authorized Representative, you are giving permission for your Authorized Representative to:

- Sign the application on your behalf
- Act on your behalf for all matters related to the application and account

Please note: An Authorized Representative is not certified by **GetCoveredNJ**. This is different than designating an Agent or a Certified Assister who has completed training and is certified by **GetCoveredNJ**.

Do you want to name someone as your Authorized Representative? *

- Yes
- No

Authorized Representative Contact Information

First Name* Middle Name Last Name*
Suffix

Authorized Representative Home Address

Home address (Leave blank if you don't have one.) * Home Address 2

Enter address here Address 2 here

City* State* Zip Code* County*

Mobile Phone Number Home Phone Number Phone Extension

Is this person part of an organization helping you apply for health insurance? *

Yes No

By checking this box and signing my name below, I am allowing the authorized representative to have access to my application and enrollment information and make changes for me.

Print Full Name Here:

Sign Full Name Here:

III. Help Paying for Coverage:

You may be eligible for a free or low-cost plan, or a tax credit or state subsidy to help pay your monthly premiums.

Do you want to find out if you can get help paying for health coverage? *

Yes. (You will have to provide income information to see what you may qualify for.)
 No. (You will pay full cost for Marketplace health coverage.)

IV. About Your Household:

<p>Are you seeking coverage? * <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><i>If yes, please fill out your information below. If NO, please skip to Applicant 2.</i></p>		
<p>First Name* Suffix</p>	<p>Middle Name</p>	<p>Last Name*</p>
<p>Date of Birth (xx/xx/xxxx):</p>		
<p>Gender*: <input type="checkbox"/> Male <input type="checkbox"/> Female</p>		
<p>Social Security Number:</p> <p>If no Social Security Number is provided, you will be required to provide additional documentation with this application. Providing a Social Security Number can help verify your eligibility to enroll in health coverage. If you do not have a Social Security Number, please visit www.ssa.gov/ssnumber to apply.</p>		
<p>Are you a U.S. citizen or U.S. National? * <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Are you a naturalized citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If YES person 1 is a naturalized citizen, please select document type:</p> <p><input type="checkbox"/> Naturalization Certificate: Alien Number: Naturalization Number:</p> <p><input type="checkbox"/> Certificate of Citizenship: Alien Number: Citizenship Certificate Number:</p> <p>If yes to citizenship, please skip to questions relating to demographics.</p> <p>If you are not a citizen or a national, please provide documentation of your immigration status: *</p> <p>Please select a document type that is being submitted with this application (copy only)</p> <p><input type="checkbox"/> Permanent Resident Card (Green Card, I-551)</p> <p><input type="checkbox"/> Temporary I-551 Stamp (on passport or I-94, I-94A)</p> <p><input type="checkbox"/> Machine Readable Immigrant Visa (With Temporary I-551 Language)</p> <p><input type="checkbox"/> Employment Authorization Card (EAD, I-766)</p> <p><input type="checkbox"/> Arrival/Departure Record (I-94, I-94A)</p> <p><input type="checkbox"/> Arrival/Departure Record in Foreign Passport (I-94)</p> <p><input type="checkbox"/> Foreign Passport</p> <p><input type="checkbox"/> Reentry Permit (I-327)</p> <p><input type="checkbox"/> Refugee Travel Document (I-571)</p> <p><input type="checkbox"/> Certificate of Eligibility for Nonimmigrant (F-1) Student Status (I-20)</p> <p><input type="checkbox"/> Certificate of Eligibility for Exchange Visitor (J-1) Status (DS2019)</p> <p><input type="checkbox"/> Notice of Action, I-797</p> <p><input type="checkbox"/> Other status</p> <p><input type="checkbox"/> None of these</p>		

<p>Have you been honorably discharged veteran or active duty member of the military? *</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>Will you be filling federal income taxes for your family for 2021? *</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If YES, will you be filing married filing joint? (with spouse listed on this application)</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>You don't have to file taxes to apply for coverage, but you will need to file next year if you want to get a premium tax credit to help pay for coverage now.</p> <p>If YES, list the dependents that will be claimed by the tax filer(s) on his/her/their income tax return:</p>	
<p>Are you considered a Federally Recognized American Indian/Alaskan Native? *</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If YES, list the State & Tribe Name of Membership?</p>	
<p>Were you found not eligible for Medicaid or NJ FamilyCare in the past 90 days? *</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If YES, provide the date of denial:</p>	
<p>Are you currently pregnant or were pregnant in the last 60-days? *</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>If YES, please list how many babies are you expecting?</p>	<p>When is your expected due date?</p>
<p>Do you have a physical disability or mental health condition that limits your ability to work, attend school, or take care of your daily needs? *</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you need help with activities of daily living (ie. Bathing, dressing, and using the bathroom), or live in a nursing home, or other medical facility? *</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>Were you ever in foster care? *</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If YES: What state were you in Foster Care?</p> <p>Were you receiving health care through Medicaid? * <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>How old were you when you left the Foster Care System?</p>	

<input type="checkbox"/> Pension: \$ How often? <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly	<input type="checkbox"/> Net farming/fishing: \$ How often? <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly
<input type="checkbox"/> Social Security: \$ How often? <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly	<input type="checkbox"/> Net rental/royalty: \$ How often? <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly
<input type="checkbox"/> Retirement accounts: \$ How often? <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly	<input type="checkbox"/> Other income: \$ How often? <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly

Deductions: Fill in all that apply, and give the amount and how often APPLICANT 1 gets it. If APPLICANT 2 pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.

Note: You shouldn't include child support that APPLICANT 1 pays, or a costs already considered in the answer to net self-employment.

<input type="checkbox"/> Alimony Received: \$ How often?	<input type="checkbox"/> Other deductions, \$ How often? <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly
<input type="checkbox"/> Student Loan Interest: \$ How often? <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly	

Complete only if APPLICANT 1's income changes during the years, like if APPLICANT 2 only works at a job for part of the year or receives a benefit for certain months. If you don't expect changes to APPLICANT 2's monthly income, skip to the the next person.

Person 1's total income this year: \$	Person 1's total income next year: \$ <input type="checkbox"/> Fill in if you think your income will be hard to predict.
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Additional Information:
Are you currently enrolled in any of the below listed health coverage options that will extend beyond 60 days from today?

Yes **No**

If YES, what type of coverage do you have?

- CHIP
- COBRA Coverage
- Marketplace Coverage
- Medicaid
- Medicare
- Peace Corps
- Retiree Health Benefits
- TRICARE
- Veterans Affairs (VA) Health Care Program
- Other Coverage
- None of the Above

Have you reconciled premium tax credits on your tax return for past years?

- Yes No I have never received premium tax credit in past years

Will you be offered health coverage through a job (including another person's job, like a spouse or parent) starting January 01, 2021? *

- Yes No

If YES, please answer:

Employer name:

Employer Phone Number:

Does your employer offer a health plan that meets the minimum value standard?

A health plan meets the minimum value standard if it is designed to pay at least 60% of the total cost of medical services for a standard population, and its benefits include substantial coverage of physician and inpatient hospital services.

If you are offered affordable coverage that meets the minimum value standards, you will not be eligible for a premium tax credit. Most job-based plans meet this standard.

Yes

No

If YES, what is the premium amount for the lowest cost plan available that meets the minimum value standard?

Total amount

How often?

Are you offered the New Jersey State Employee Health Benefit plan through a job or a family member's job? *

- Yes No

Would you like help paying for medical bills from the last 3 months? *

Note: GetCoveredNJ coverage is not retroactive. If you are eligible for Medicaid, you may receive some financial help for past bills.

- Yes No

Is there a parent living outside of the home?

- Yes No

Applicant 2: If you have more than two applicants, please print an additional form to attach to application.

First Name*	Middle Name	Last Name*
Suffix		
Date of Birth (xx/xx/xxxx):		
Gender*: <input type="checkbox"/> Male <input type="checkbox"/> Female		
Please define the relationship to this applicant*:		
Does Applicant 2 live with the person applying? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, list address		
Social Security Number: If no Social Security Number is provided, you will be required to provide additional documentation with this application. Providing a Social Security Number can help verify your eligibility to enroll in health coverage. If you do not have a Social Security Number, please visit www.ssa.gov/ssnumber to apply.		
Are you a U.S. citizen or U.S. National? * <input type="checkbox"/> Yes <input type="checkbox"/> No		
Are you a naturalized citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If YES, please select document type:		
<input type="checkbox"/> Naturalization Certificate: Alien Number: Naturalization Number:		
<input type="checkbox"/> Certificate of Citizenship: Alien Number: Citizenship Certificate Number: If yes to citizenship, please skip to questions relating to demographics.		
If you are not a citizen or a national, please provide documentation of your immigration status: *		
Check if Applicant 2 has eligible immigration status Please select a document type		
<input type="checkbox"/> Permanent Resident Card (Green Card, I-551)		
<input type="checkbox"/> Temporary I-551 Stamp (on passport or I-94, I-94A)		
<input type="checkbox"/> Machine Readable Immigrant Visa (With Temporary I-551 Language)		
<input type="checkbox"/> Employment Authorization Card (EAD, I-766)		
<input type="checkbox"/> Arrival/Departure Record (I-94, I-94A)		
<input type="checkbox"/> Arrival/Departure Record in Foreign Passport (I-94)		
<input type="checkbox"/> Foreign Passport		
<input type="checkbox"/> Reentry Permit (I-327)		
<input type="checkbox"/> Refugee Travel Document (I-571)		
Certificate of Eligibility for Nonimmigrant (F-1) Student Status (I-20)		
<input type="checkbox"/> Certificate of Eligibility for Exchange Visitor (J-1) Status (DS2019)		
<input type="checkbox"/> Notice of Action, I-797		

- Other status
- None of these

Does Applicant 2 also have any of these documents? (Select all that apply)

- Certification from U.S. Department of Health and Human Services (HHS) Office of Refugee Resettlement (ORR)
- Office of Refugee Resettlement (ORR) Eligibility Letter (if Under 18)
- Cuban/Haitian Entrant
- Resident of American Samoa
- Battered spouse, child, or parent under Violence Against Women Act
- Document indicating member of federally recognized Indian tribe or American Indian born in Canada
- Document indicating withholding of removal
- None of these

Is Applicant 2's name provided on this application the same name that appears on the document?

- Yes
- No

If **NO**, enter full name:

First Name*	Middle Name	Last Name*
Suffix		

Has **Applicant 2's** primary residence been in the U.S. since 1996?

- Yes
- No

If **NO**:

Has **Applicant 2** had their current immigration status for the last 5 years?

- Yes
- No

Optional: These questions are optional, and you do not need to answer them to apply for health insurance. If you choose to answer them, GetCoveredNJ will use this information to get a better understanding of the demographics and health needs of New Jerseyans. This information will also be shared with the Department of Health and Human Services to support a broader understanding of health needs across the U.S. population.

Are you of Hispanic, Latino, or Spanish Origin? Yes No

- Race** (Check all that apply): American Indian or Alaska Native Asian Indian
- Black or African American Chinese Filipino Guamanian or Chamorro
- Japanese Korean Native Hawaiian Other Asian
- Other Pacific Islander Samoan Vietnamese White or Caucasian
- Other

Mandatory question below, please answer to the best of your ability.

Are you currently married? * Yes No

If yes, who is your spouse? *

Someone already on the application. Name of Applicant:

Someone else who isn't applying for health coverage

Have you been honorably discharged veteran or active duty member of the military?

Yes No

Will you be filling federal income taxes for your family for 2021? *

Yes No

If YES, will you be filing married filing joint? (with spouse listed on this application)

Yes No

You don't have to file taxes to apply for coverage, but you will need to file next year if you want to get a premium tax credit to help pay for coverage now.

If YES, please list the dependents that will be claimed by the tax filer(s) on his/her/their income tax return?

Are you considered a Federally Recognized American Indian/Alaskan Native? *

Yes No

If YES, please list the State & Tribe Name of Membership?

Were you found not eligible for Medicaid or NJ FamilyCare in the past 90 days? *

Yes No

If YES, please provide the date of denial:

Are you currently pregnant or were pregnant in the last 60-days?

Yes No

If YES, please list how many babies are you expecting?	When is your expected due date?		
<p>Do you have a physical disability or mental health condition that limits your ability to work, attend school, or take care of your daily needs? *</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you need help with activities of daily living (ie. Bathing, dressing, and using the bathroom), or live in a nursing home, or other medical facility? *</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>			
<p>Were you ever in foster care? *</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If YES: What state were you in Foster Care?</p> <p>Were you receiving health care through Medicaid? * <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>How old were you when you left the Foster Care System?</p>			
Current job & income information:			
<input type="checkbox"/> Employed: If you're currently employed, tell us about your income. Start with the next line below.	<input type="checkbox"/> Not employed: Skip to section starting "Other Income"	<input type="checkbox"/> Self-employed: skip to section starting "If self-employed"	
<p>Current job 1:</p> <p>Employer name:</p>			
<p>Employer address (optional):</p>			
<p>City:</p>	<p>State:</p>	<p>Zip Code:</p>	<p>Employer phone number:</p>
<p>Wages/tips (before taxes): \$</p> <p><input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly</p>			<p>Average hours worked each WEEK:</p>

Have you reconciled premium tax credits on your tax return for past years?

- Yes No I have never received premium tax credit in past years

Will you be offered health coverage through a job (including another person's job, like a spouse or parent) starting January 01, 2021? *

- Yes No

If YES, please answer:

Employer name:

Employer Phone Number:

Does your employer offer a health plan that meets the minimum value standard?

A health plan meets the minimum value standard if it is designed to pay at least 60% of the total cost of medical services for a standard population, and its benefits include substantial coverage of physician and inpatient hospital services.

If you are offered affordable coverage that meets the minimum value standards, you will not be eligible for a premium tax credit. Most job-based plans meet this standard

Yes

No

If YES, what is the premium amount for the lowest cost plan available that meets the minimum value standard?

Total amount

How often?

Are you offered the New Jersey State Employee Health Benefit plan through a job or a family member's job? *

- Yes No

Would you like help paying for medical bills from the last 3 months? *

Note: GetCoveredNJ coverage is not retroactive. If you are eligible for Medicaid, you may receive some financial help for past bills.

- Yes No

If you are applying for additional applicants, please reprint this page and attach with your application.

V. Your agreement and signature

Read and check the box next to each statement if you agree

Are any applicants incarcerated (in prison or jail) *

- No. No one listed on this health insurance application is incarcerated (in prison or Jail).
 Yes, please fill out the name(s) of those applying.

If yes, is this person pending disposition?

- Yes
 No

To make it easier to determine my eligibility for help paying for coverage in future years, I agree to allow the Health Insurance Marketplace to use my income data, including information from tax returns, for the next 5 years. The Marketplace will send me a notice and let me make changes. I can opt out at any time. *

- I agree
 I disagree

I understand that if anyone on my application enrolls in a Marketplace health plan and is later found to have other qualifying health coverage (including Medicare, Medicaid, or CHIP), the Marketplace will automatically end their Marketplace health plan. *

If anyone on this application enrolls in Medicaid, I am giving the Medicaid agency the right to pursue and get any money from other health insurance, legal settlements, or other third parties. I am also giving the Medicaid agency rights to pursue and get medical support from a spouse or parent. *

If a child on this application has a parent living outside of the home, I know I will be asked to cooperate with the agency that collects medical support from an absent parent. If I think that cooperating to collect medical support will harm me or my children, I can tell the agency and I may not have to cooperate. *

I understand that I have 30 days to notify the Marketplace of any change of information in this application. I will report any changes within 30 days of change. I understand that changes in my income, household size, address or other details might affect my or my household's eligibility for specific benefits. I understand and will notify the Marketplace if my application information changes. *

I understand that my application will be used to evaluate eligibility for health coverage through GetCoveredNJ or Medicaid/CHIP (NJ FamilyCare). If I enroll in Medicaid, I acknowledge that the NJ Division of Medical Assistance and Health Services can file a claim and lien against the estate of a deceased Medicaid beneficiary to recover all Medicaid payments for services received on or after age 55 **Estate Recovery - What You Should Know** (https://www.state.nj.us/humanservices/dmahs/clients/The_NJ_Medicaid_Program_and_Estate_Recovery_What_You_Should_Know.pdf or call 1-800-356-1561 to request a paper copy). I understand that estate recovery only applies to Medicaid and it is not applicable to enrollment in a health plan through GetCoveredNJ.

If you are not registered to vote where you live now and would like to apply to register to vote, please visit the link below:

<https://www.state.nj.us/state/elections/voter-registration.shtml>

By signing my name in the box below, I'm signing this application under penalty of perjury, which means I've provided true answers to all of the questions to the best of my knowledge. I know I may be subject to penalties under state and federal law if I intentionally provide false information.

Signature:

Date:

VI. Mail Completed Application



Mail your signed application to:

Get Covered New Jersey Consumer Assistance Center
PO Box 55898 Trenton, NJ 08638

Get help in a language other than English

Here's a listing of the available languages:

<p>English If you, or someone you're helping, has questions about Get Covered New Jersey, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-833-677-1010.</p>	<p>Arabic إن كان لديك أو لدى شخص تساعد أسئلة بخصوص Get Covered New Jersey فلديك الحق في الحصول على المساعدة والمعلومات الضرورية، بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بـ 1-833-677-1010</p>
<p>Spanish Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Get Covered New Jersey Español, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-833-677-1010.</p>	<p>Russian Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Get Covered New Jersey, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-800-446-7467.</p>
<p>Chinese 如果您，或您正在幫助的人，有關於 Get Covered New Jersey 方面的問題，您有權利免費以您的母語得到幫助和訊息。想要跟一位翻譯員通話，請致電 1-833-677-1010。</p>	<p>Tagalog Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Get Covered New Jersey, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-833-677-1010.</p>
<p>Korean 만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Get Covered New Jersey 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-833-677-1010 로 전화하십시오</p>	<p>French Creole Si oumenm oswa yon moun w ap ede gen kesyon konsènan Get Covered New Jersey, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 1-833-677-1010.</p>
<p>Portuguese Se você, ou alguém a quem você está ajudando, tem perguntas sobre o Get Covered New Jersey, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-833-677-1010.</p>	<p>Hindi यदि आपको, या आप जिस व्यजति की सहायिा कर रहे हैं, उन्हें इस विषय Get Covered New Jersey के बारे में सिल हैं, िो आपको मुफ्ि में अपनी भाषा में सहायिा िथा िानकारी लेने का अधिकार है। 1-833-677-1010 पर फ़ोन करें।</p>
<p>Gujarati જો તમે અથવા તમે કોઈને મદદ કરી રહ્યાં તે માંથી કોઈને Get Covered New Jersey વલણે પ્રશ્નો હોય તો તમને મદદ અને માહત્તી મેળવવાનો અધિકાર છે. તેમજ વલણ તમારી ભાષામાં પ્રાપ્ત કરી શકાય છે. દુભાવણો વાત કરવા માટે, આ 1-833-677-1010 પર કોલ કરો.</p>	<p>Vietnamese Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Get Covered New Jersey, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình hoàn toàn miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-833-677-1010</p>
<p>Polish Jeśli Ty lub osoba, której pomagasz ,macie pytania odnośnie Get Covered New Jersey, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-833-677-1010</p>	<p>French Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Get Covered New Jersey, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-833-677-1010</p>

Italian

Se tu o qualcuno che stai aiutando avete domande su [Get Covered New Jersey](#) hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare [1-833-677-1010](tel:1-833-677-1010)

Urdu

اگر آپ کسی کو مدد دے رہے ہیں اور آپ دونوں کو سوال اگر آپ کسی کو [Get Covered New Jersey](#) مدد دے رہے ہیں اور آپ دونوں کو سوال ہے بارے میں، تو آپ دونوں کو اپنی زبان میں مفت مدد اور معلومات [Jersey](#) حاصل کرنے کا حق ہے۔ ترجمان سے بات کرنے کے لیے، (1-- فون کریں۔) 0101776338