Get Covered NJ
New Jersey's Official Health Insurance Marketplace

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 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 these policies apply to GetCoveredNJ and NJ FamilyCare.**

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*
☐ 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

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
☐ 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 *(MM/DD/YYYY):*	**Email:** ☐ *Send me important alerts to this email address*

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

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 go to Phone Number*

Primary Contact mailing address (Leave blank if you don't have one.) *	**Mailing Address 2**

City*	**State***	**Zip Code***	**County***

Mobile Phone Number ☐ *Send me important alerts to this phone number. Standard message rates may apply.*	**Home Phone Number**	**Phone Extension**

Primary Contact Preference:

Preferred Spoken Language *(please fill in)*:		
Preferred Written Language *(please fill in)*:		
Preferred Method of Communication*	☐ **Go Paperless** / Electronic Mailbox	☐ **Postal Mail**
How do you wish to receive your 1095-A form*	☐ **Go Paperless** / Electronic Mailbox	☐ **Postal Mail**

II. Help Applying for Coverage:

Is anyone helping you with this application? *

☐ A friend or family member is helping me
☐ I am being helped by a certified health insurance agent/broker or assister
☐ 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 you, fill out thebelow information. IF NOT, go to Section III "Help Paying for Coverage."

Agent / Assistor / Broker Information

Agent / Assistor / Broker Contact Information

First Name*	Middle Name	Last Name*	Suffix

Agent / Assistor / Broker Home Address

Home address (Leave blank if you don't have one.) *			
City*	**State***	**Zip Code***	**County***

Mobile Phone Number	Home Phone Number	Phone Extension

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 Assistor 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.) *			
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:

Are you seeking coverage? * ☐ Yes ☐ No

If yes, please fill out your information below. If no, please go to Applicant 2.

First Name*	**Middle Name**	**Last Name***	**Suffix**

Date of Birth *(MM/DD/YYYY):*

Sex*: ☐ Male ☐ Female

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? * ☐ Yes ☐ No

Are you a naturalized citizen? ☐ Yes ☐ No

If yes, person 1 is a naturalized citizen, please select document type:

☐ Naturalization Certificate:
Alien Number:
Naturalization Number:

☐ 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: *

Please select a document type that is being submitted with this application (copy only)

☐ Permanent Resident Card (Green Card, I-551)
☐ Temporary I–551 Stamp (on passport or I–94, I–94A)
☐ Machine Readable Immigrant Visa (With Temporary I-551 Language)
☐ Employment Authorization Card (EAD, I-766)
☐ Arrival/Departure Record (I-94, I-94A)
☐ Arrival/Departure Record in Foreign Passport (I-94)
☐ Foreign Passport
☐ Reentry Permit (I-327)
☐ Refugee Travel Document (I-571)
☐ Certificate of Eligibility for Nonimmigrant (F-1) Student Status (I-20)
☐ Certificate of Eligibility for Exchange Visitor (J-1) Status (DS2019)
☐ Notice of Action, I-797
☐ Other status
☐ None of these

Does Applicant 1 also have any of these documents?

☐ 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 1'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 1**'s primary residence been in the U.S. since 1996?

☐ Yes
☐ No

If **NO:**

Has **Applicant 1** 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	☐ Guamanian or Chamorro	☐ Other Pacific Islander
☐ Asian Indian	☐ Japanese	☐ Samoan
☐ Black or African American	☐ Korean	☐ Vietnamese
☐ Chinese	☐ Native Hawaiian	☐ White or Caucasian
☐ Filipino	☐ Other Asian	☐ 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

Are you an honorably discharged veteran or active-duty member of the military? *

☐ Yes ☐ No

Will you be filing federal income taxes for your family for 2024? *

☐ Yes ☐ No

If YES and you are married, will you be filing a married joint tax return with your spouse listed on this applicant (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, 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, 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, provide the date of denial:

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

☐ Yes ☐ No

If YES, please list how many babies are you expecting:	**When is your expected due date?**

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? *

☐ Yes ☐ No

Do you need help with activities of daily living (i.e.. Bathing, dressing, and using the bathroom), or live in a nursing home, or other medical facility? *

☐ Yes ☐ No

Were you ever in foster care? *

☐ Yes ☐ No

If YES, what state were you in foster care?

Were you receiving health care through Medicaid? * ☐ Yes ☐ No

How old were you when you left the Foster Care System?

Current job & income information:		
☐ **Employed:** If you're currently employed, tell us about your income. Start with the next line below.	☐ **Not employed:** Skip to section starting "Other Income"	☐ **Self-employed:** Skip to section starting "If self-employed"

Current job 1:
Employer name:

Wages/tips (before taxes): $ ☐ Hourly ☐ Weekly ☐ Twice a month ☐ Monthly ☐ Yearly	**Average hours worked each WEEK:**

Current job 2: (if you have additional jobs and need more space, attach another sheet of paper to your application.)
Employer name:

Wages/tips (before taxes): $ ☐ Hourly ☐ Weekly ☐ Twice a month ☐ Monthly ☐ Yearly	**Average hours worked each WEEK:**

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

If self-employed, answer a and b:
a. Type of work:
b. How much net income (profits once business expenses are paid) you will get this from self-employment this month?

Other income you get this month: Fill in all that apply and give the amount and how often you get it.
Fill in here if none ☐
Note: You **don't** need to tell us about income from child support, veteran's payments, or Supplemental Security Income (SSI).

☐ **Unemployment: $** How often? ☐ Hourly ☐ Weekly ☐ Twice a month ☐ Monthly ☐ Yearly	☐ **Alimony Received: $** How often? ☐ Hourly ☐ Weekly ☐ Twice a month ☐ Monthly ☐ Yearly
☐ **Pension: $** How often? ☐ Hourly ☐ Weekly ☐ Twice a month ☐ Monthly ☐ Yearly	☐ **Net farming/fishing: $** How often? ☐ Hourly ☐ Weekly ☐ Twice a month ☐ Monthly ☐ Yearly
☐ **Social Security: $** How often? ☐ Hourly ☐ Weekly ☐ Twice a month ☐ Monthly ☐ Yearly	☐ **Net rental/royalty: $** How often? ☐ Hourly ☐ Weekly ☐ Twice a month ☐ Monthly ☐ Yearly
☐ **Retirement accounts: $** How often? ☐ Hourly ☐ Weekly ☐ Twice a month ☐ Monthly ☐ Yearly	☐ **Other income: $** How often? ☐ Hourly ☐ Weekly ☐ Twice a month ☐ Monthly ☐ Yearly

Deductions: Fill in all that apply, and give the amount and how often APPLICANT 1 gets it. If APPLICANT 1 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.

☐ **Alimony Received: $**
How often?
☐ Hourly ☐ Weekly ☐ Twice a month ☐ Monthly
☐ Yearly

☐ **Student Loan Interest: $**
How often?
☐ Hourly ☐ Weekly ☐ Twice a month ☐ Monthly
☐ Yearly

☐ **Other deductions: $**
How often?
☐ Hourly ☐ Weekly ☐ Twice a month ☐ Monthly
☐ Yearly

Complete only if APPLICANT 1's income changes during the years, i.e. if APPLICANT 1 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 1's monthly income, skip to the next person.

Applicant 1's total income this year: $

Applicant 1's total income next year: $
☐ Fill in if you think your income will be hard to predict.

Additional Information:
Are you currently enrolled in any of the below listed health coverage options that will extend beyond 60 days from today? If the current coverage is Marketplace coverage through GetCoveredNJ, answer No.
☐ **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, I received financial help in prior years, and reported it (you did not need to report 2020)
☐ No, I received financial help in prior years, but did not report it (you did not need to report 2020)
☐ I have not received financial help before, or I only received financial help in 2020 and/or 2023
*Due to the American Rescue Plan Act (ARPA), the requirement to repay excess advance premium tax credits was suspended for tax year 2020. Therefore consumers were not required to reconcile premium tax credits for 2020.

Will you be offered health coverage through a job (including another person's job, like a spouse or parent) starting January 1, 2024? *
☐ 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 *(MM/DD/YYYY):*

Sex*: ☐ Male ☐ Female

Please define the relationship to this applicant*:

Does Applicant 2 live with the person applying? ☐ Yes ☐ 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? * ☐ Yes ☐ No
Are you a naturalized citizen? ☐ Yes ☐ No

If YES, please select document type:

☐ Naturalization Certificate:
Alien Number:
Naturalization Number:

☐ 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

☐ Permanent Resident Card (Green Card, I-551)
☐ Temporary I−551 Stamp (on passport or I−94, I−94A)
☐ Machine Readable Immigrant Visa (With Temporary I-551 Language)
☐ Employment Authorization Card (EAD, I-766)
☐ Arrival/Departure Record (I-94, I-94A)
☐ Arrival/Departure Record in Foreign Passport (I-94)
☐ Foreign Passport
☐ Reentry Permit (I-327)
☐ Refugee Travel Document (I-571)
☐ Certificate of Eligibility for Nonimmigrant (F-1) Student Status (I-20)
☐ Certificate of Eligibility for Exchange Visitor (J-1) Status (DS2019)
☐ 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

Are you an honorably discharged veteran or active-duty member of the military?

☐ Yes ☐ No

Will you be filing federal income taxes for your family for 2024? *

☐ 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?

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? *

☐ Yes ☐ No

Do you need help with activities of daily living (i.e. Bathing, dressing, and using the bathroom), or live in a nursing home, or other medical facility? *

☐ Yes ☐ No

Were you ever in foster care? *

☐ Yes ☐ No

If YES: What state were you in Foster Care?

Were you receiving health care through Medicaid? * ☐ Yes ☐ No

How old were you when you left the Foster Care System?

Current job & income information:

☐ **Employed:** If you're currently employed, tell us about your income. Start with the next line below.	☐ **Not employed:** Skip to section starting "Other Income"	☐ **Self-employed:** Skip to section starting "If self-employed"

Current job 1:

Employer name:

Employer address (optional):

City:	**State:**	**Zip Code:**	**Employer phone number:**

Wages/tips (before taxes): $

☐ Hourly ☐ Weekly ☐ Twice a month ☐ Monthly ☐ Yearly

Average hours worked each WEEK:

Current job 2: (if you have additional jobs and need more space, attach another sheet of paper to your application.)

Employer name:

Employer address (optional):

City:	**State:**	**Zip Code:**	**Employer phone number:**

Average hours worked each WEEK:

In the past year, did you:

☐ Change jobs? ☐ Stop working ☐ Start working fewer hours ☐ None of these

If self-employed, answer a and b:

a. Type of work:

b. How much net income (profits once business expenses are paid) you will get this from self-employment this month?

Other income you get this month: Fill in all that apply and give the amount and how often you get it. Fill in here if none☐
Note: You **don't** need to tell us about income from child support, veteran's payments, or Supplemental Security Income (SSI).

☐ **Unemployment: $** How often? ☐ Hourly ☐ Weekly ☐ Twice a month ☐ Monthly ☐ Yearly	☐ **Alimony Received: $** How often? ☐ Hourly ☐ Weekly ☐ Twice a month ☐ Monthly ☐ Yearly
☐ **Pension: $** How often? ☐ Hourly ☐ Weekly ☐ Twice a month ☐ Monthly ☐ Yearly	☐ **Net farming/fishing: $** How often? ☐ Hourly ☐ Weekly ☐ Twice a month ☐ Monthly ☐ Yearly
☐ **Social Security: $** How often? ☐ Hourly ☐ Weekly ☐ Twice a month ☐ Monthly ☐ Yearly	☐ **Net rental/royalty: $** How often? ☐ Hourly ☐ Weekly ☐ Twice a month ☐ Monthly ☐ Yearly
☐ **Retirement accounts: $** How often? ☐ Hourly ☐ Weekly ☐ Twice a month ☐ Monthly ☐ Yearly	☐ **Other income: $** How often? ☐ Hourly ☐ Weekly ☐ Twice a month ☐ Monthly ☐ Yearly

Deductions: Fill in all that apply and give the amount and how often APPLICANT 2 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 2 pays, or a cost already considered in the answer to net self-employment.

☐ **Alimony Received: $** How often? ☐ Hourly ☐ Weekly ☐ Twice a month ☐ Monthly ☐ Yearly	☐ **Other deductions: $** How often? ☐ Hourly ☐ Weekly ☐ Twice a month ☐ Monthly ☐ Yearly

☐ **Student Loan Interest: $** **How often?** ☐ Hourly ☐ Weekly ☐ Twice a month ☐ Monthly ☐ Yearly	

Complete only if APPLICANT 2's income changes during the years, i.e., 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 next person.

Applicant 2's total income this year: $	**Applicant 2's total income next year: $** ☐ Fill in if you think your income will be hard to predict.

Additional Information:

Are you currently enrolled in any of the below listed health coverage options that will extend beyond 60 days from today? If the current coverage is Marketplace coverage through GetCoveredNJ, answer No.

☐ 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, I received financial help in prior years, and reported it (you did not need to report 2020)
☐ No, I received financial help in prior years, but did not report it (you did not need to report 2020)
☐ I have not received financial help before, or I only received financial help in 2020 and/or 2023

***Due to the American Rescue Plan Act (ARPA), the requirement to repay excess advance premium tax credits was suspended for tax year 2020. Therefore consumers were not required to reconcile premium tax credits for 2020.**

Will you be offered health coverage through a job (including another person's job, like a spouse or parent) starting January 01, 2024? *

☐ 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. ***
☐ **I understand that any financial help I receive from the federal government through Advance Premium Tax Credits is connected to my taxes. I understand I may owe taxes, or receive more tax credit, if my income for the year is different than what I estimated. I agree to file federal income taxes (jointly if married) and report the amount of Advance Premium Tax Credits received on my Tax Return for any year I have federal financial help to lower premium costs.**
☐ **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:

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.	**Arabic** إن كان لديك أو لدى شخص تساعده أسئلة بخصوص Get Covered New Jersey فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون(، اية تكلفة. للتحدث مع مترجم اتصل بـ 1-0101776338
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.	**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.
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。	**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.
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	**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.
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.	**Hindi** यदि आपको, या आप जिस व्यजति की सहायिा कर रहे हैं, उन्हें इस विषय Get Covered New Jersey के बारे में सिाल हैं, िो आपको मुफ्ि में अपनी भाषा में सहायिा िथा िानकारी लेने का अधिकार है। 1-833-677-1010 पर फ़ोन करें।
Gujarati જો તમેઅથવા તમેકોઇનેમદદ કરી રહ્ાો્તેમાાંથી કોઇને Get Covered New Jersey વવશે પ્રશ્નો હોય તો તમનેમદદ અનેમાહહતી મેળવવાનો અવિકાર છે. તેખર્યવવના તમારી ભાષામાાંપ્રાપ્ત કરી શકાય છે. દુભાવષયો વાત કરવા માટે,આ 1-833-677-1010 પર કોલ કરો.	**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
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	**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
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	**Urdu** اگر اپ کسی کو مدد دے رہے ہیں اور اپ دونوں کو سوال اگر اپ کسی کو مدد دے رہے ہیں اور اپ دونوں کو سوال ہے Get Covered New Jerseyبارے میں، تو اپ دونوں کو اپنی زبان میں مفت مدد اور معالومات حاصل کرنے کا حق ہے۔ ترجمان سے بات کرنے کےلیے، 1--0101776338)فون کریں۔