Application for Premium Waiver or Reduction

MASSACHUSETTS HEALTH CONNECTOR

Use this form if you:

- Qualify for or are enrolled in a ConnectorCare plan,
- Have had an extreme financial hardship listed in **Part 3**, and
- Want to find out if you qualify for a waiver or reduction of your monthly insurance premium

If you qualify, you might get up to an 12-month premium waiver (pay $0 monthly) or reduction (pay lower cost). This could be for money you owe the Health Connector for a past balance or for money you will owe for your future premium.

PART 1 Tell us about yourself

Name *(first, middle, last)*:

Date of birth	Last 4 digits of SSN: ___ ___ ___ ___	Phone number

Street address

City	State	Zip Code

Member ID (12-digit ID, on your eligibility and enrollment letters): ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

PART 2 Tell us about your request

I request **(Check all that apply)**:

☐ Reduction of future premium

☐ Reduction of past due premium

☐ Waiver of future premium

☐ Waiver of past due premium

Premium amount I can afford to pay each month: $ _____

PART 3 Tell us about your hardship

I request a waiver or reduction because **one or more** of the situations below applies to me and my family and I can provide any required proof **(Check all that apply)**:

☐ I am homeless or had a large increase in essential expenses in the past **6 months** due to domestic violence.
Proof: None needed

☐ One or more of the following is true:

- I got a shut-off notice from my utility company (gas, electric, oil, water, or telephone) within the past **60** days, **or**
- One of my utilities has been shut off in the past **60** days, **or**
- One or more of my utility companies is refusing to deliver services because I cannot pay, **and/or**
- I am more than **30** days behind in rent or mortgage payments, or
- I got an eviction or foreclosure notice in the past **60** days

Proof: Provide any bills, receipts, or letters from your landlord, mortgage, and/or utility company.

Questions?

For questions about your Premium Hardship Waiver eligibility or to report changes to your income, call Customer Service at **1-877-MA-ENROLL** (1-877-623-6765).

PART 3 Tell us about your hardship *(continued)*

☐ I had a large increase in essential expenses in the past 6 months due to:
- Major illness I or a family member suffered, **or**
- Death of my spouse, family member, or partner with primary responsibility for childcare, or
- A working parent needs to leave employment or hire a full-time caregiver to provide care for a family member who is suffering from a major long illness

Proof: Provide any bills or receipts.

☐ I had a large increase in essential expenses in the past 6 months due to a fire, flood, natural disaster, or other unexpected natural or human-caused event that:
- Caused my necessary personal expenses to become unaffordable, **or**
- Caused large damage to me or my home, property or personal possessions

Proof: Provide any bills, receipts, or letters from your landlord, mortgage, and/or utility company.

☐ I filed for bankruptcy in the past 12 months and my debts have not been discharged.

Proof: Provide any evidence of bankruptcy filing.

Comments: (If you need more space, attach a piece of paper.)

PART 4 Read and sign

I certify that:

- I have read, or had read to me, the information on this Waiver-Reduction Application, and
- I understand my rights and responsibilities, and
- Under penalty of perjury, that the information on this Application, and any attachments or supplements to it, are correct and complete to the best of my knowledge

I authorize the release of my personal health information and other confidential data to the Health Connector and Health Connector-contracted entities for the purpose of making a decision on my Waiver-Reduction Application.

First and last name (print)	Signature (sign)	Date

☐ Check here if you are a Representative signing for the named individual. You must have an Authorized Representative Designation (ARD) Form identifying you to provide and receive information for the named individual. If you don't have an ARD, send a completed ARD Form to the Massachusetts Health Connector with your proof. Keep a copy for your records. You can find the ARD Form at www.mass.gov/doc/authorized-representative-designation-form-1.

PART 5 How to send proof

Send copies of your proof. We will not return originals. Keep a copy for your records.

Mail:
Health Connector Processing Center
PO Box 4404
Taunton, MA 02780

Fax:
617-887-8745

Online:
Sign into account at MAhealthconnector.org. Upload completed form and proof at My Documents.