You may use this form if you experienced extreme financial hardship and want to find out if you qualify for a waiver or reduction of your monthly insurance premium. If you qualify, you may be able to get up to an 11-month waiver (meaning you don’t have to pay) or reduction (meaning you pay less) for the cost of your monthly premium. This could be for money that you owe the Health Connector for a previous balance, or money that you will owe for your future premium.

**Note:** A change in your income on its own is not considered for purposes of the hardship waiver or reduction. If your income has changed, update your account at MAhealthconnector.org, or call 1-877-MA-ENROLL (877-623-6765).

### Filling out this application

- You must fill out this form completely. Do not leave any sections blank
- You must also send proof with this form
- Only certain financial hardship events qualify for a waiver or reduction. They are listed in Section 3. If you have a question or problem that does not fit within one of the circumstances listed in Section 3, please call Customer Service at 1-877-MA-ENROLL (877-623-6765). In order to qualify, you must prove that you have experienced at least one of these events
- The most amount of time you can receive a waiver or reduction is 11 months. However, you may be able to file another application if you continue to meet one or more of the hardship events
- Only individuals or families who qualify for or are enrolled in a ConnectorCare plan can get a waiver or reduction for their premium
- You may file a Waiver-Reduction Application at any time unless you are already receiving a waiver of premiums.

### Paying your premiums

The premium waiver or reduction may be requested prior to enrollment but does not mean that you can automatically enroll at a reduced premium or no premium.

If you are already enrolled in a plan, you are required to pay your monthly premiums while the premium waiver or reduction request is being processed. Non-payment of premium will result in termination for non-payment in accordance with the Health Connector policy. (Health Connector policy NG-6B).

If your Application is denied and you appeal that decision, you will have to pay premiums while you wait for a decision on your appeal. If you fail to make your premium payments, you may be disenrolled.

### Help with this form

If you need help completing this application, please contact the Health Connector. Please mail or fax this application, proof of your hardship, and any other materials for us to consider.

**If I am approved, how can I get the most help paying my monthly premium?**

To make your premiums as low as possible, you need to take the full amount in premium tax credits that you qualify for and enroll in the lowest-cost health plan in your area. Otherwise, you might still have to pay a monthly premium, even if you are approved for a premium waiver or reduction.
You can switch plans or change your premium tax credit amount from your online account at MAhealthconnector.org. Or, Customer Service can help you over the phone at 1-877-MA-ENROLL (877-623-6765).

Sending proof

Please send photocopies of your proof as 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 your account at MAhealthconnector.org and upload your completed form and supporting proof in the My Documents section
Application for a Premium Waiver or Reduction

SECTION 1: Print your information
(Please print clearly)

<table>
<thead>
<tr>
<th>First Name</th>
<th>Middle Name</th>
<th>Last Name</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Mailing address</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
<tbody>
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<td></td>
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</table>

<table>
<thead>
<tr>
<th>Phone number</th>
<th>Last 4 digits of Social Security Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Member ID (this is your 12-digit ID, found on your eligibility and enrollment notices): ______________

SECTION 2: Waiver or reduction request
I am requesting a:

- [ ] Reduction of future premium
- [ ] Waiver of future premium
- [ ] Reduction of past due premium
- [ ] Waiver of past due premium

What premium amount can you afford to pay each month? $ ______________

SECTION 3: Your hardship
Which event(s) listed below best describes your reason for requesting a waiver or reduction?

- [ ] You are homeless, or more than 30 days behind in rent or mortgage payments, or have received an eviction or foreclosure notice within the past 60 days.
- [ ] You received a shut-off notice from your utility company (gas, electric, oil, water, or telephone) within the past 60 days, or one of your utilities has been shut off within the past 60 days, or one or more of your utility companies is refusing to deliver services because you cannot pay.
- [ ] You had a large increase in essential expenses in the past six months due to domestic violence.
- [ ] You had a large increase in essential expenses in the past six months due to death of your spouse, family member, or partner with primary responsibility for childcare.
- [ ] You had a large increase in essential expenses in the past six months because you or a person in your family suffered from a major illness, including COVID-19. This could include an increase in expenses related to the need to self-quarantine after risk of exposure to COVID-19. The increase in expenses could also be related to a working parent needing to leave employment or hire a full-time caregiver to provide care for a family member who is suffering from a major long illness.
- [ ] You had a large increase in essential expenses in the past six months due to a fire, flood, natural disaster, or other unexpected natural or human-caused event. This could include circumstances due to the coronavirus (COVID-19) pandemic, such as facing large expenses...
after losing your income. The event caused your necessary personal expenses to become unaffordable, or it caused large damage to you, your home, your property or personal possessions.

☐ You have filed for bankruptcy within the past twelve months and the debts have not yet been discharged.

For each event(s) you checked, please describe what happened below. Attach additional sheets if necessary.

SECTION 4: Proof of Hardship

Please attach evidence (proof) of your hardship. Evidence of your hardship must include copies (do not send originals as they will not be returned) of relevant documentation. This could include:

- Bills
- Receipts
- Letters from your landlord, mortgage, and/or utility company

You do not have to provide proof of hardship at this time if your reason for the request relates to:

- Domestic violence
- Homelessness
- Coronavirus pandemic (COVID-19)

Note: If your request relates to COVID-19, we may ask you to send proof at a later date.

SECTION 5: Member Certification

I certify that I have read, or had read to me, the information on this Waiver-Reduction Application and that I understand my rights and responsibilities. I further certify under the 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 further 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 Name and Last Name (Print)      Signature (Sign)              Date

☐ Check here if you are a Representative signing on behalf of the named individual. If so, and if you have not already done so, you must fill out the Authorized Representative Designation Form to provide and receive information for the named individual. Send this to the Massachusetts Health Connector with your proof. Keep a copy for your records.

Designation of Representative

You may, but are not required to, designate someone as your Authorized Representative to help you with the responsibilities of applying for, or getting health care coverage. To designate an Authorized Representative to receive information on your behalf regarding your eligibility, enrollment, and Waiver Reduction Application, you must submit an Authorized Representative Designation Form that is signed by both you and/or your Representative. The Connector will only accept the Representative named on the Representative Form. By designating this Representative, you are authorizing the Connector to share your personal health and financial information with that Representative. To
submit the Authorized Representative Designation Form, call the Health Connector. You can also sign on to your account at MAhealthconnector.org to designate an Authorized Representative.

**Send this form and your proof in one of the following ways:**

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

**Fax**  
617-887-8745

**Online**  
Sign into your account at MAhealthconnector.org and upload your completed form and supporting proof in the *My Documents* section