



*The Commonwealth of Massachusetts
Health Policy Commission
Office of Patient Protection
Two Boylston Street, 6th Floor
Boston, MA 02116
(800)436-7757 (phone)
(617)624-5046 (fax)*

2014 Insurance Enrollment Waiver Information and Instructions

Massachusetts and federal law limit when you can buy certain health insurance plans. Some people may meet special conditions and can buy insurance at any time. Others must buy insurance during the open enrollment periods.

**The 2014-2015 open enrollment periods are: January 1, 2014 - March 31, 2014
November 15, 2014 – February 15, 2015**

If you are a Massachusetts resident and missed the open enrollment period, then you might qualify for a waiver of the open enrollment period if you meet certain criteria. You may use this form to request a waiver to enroll in health insurance coverage outside of open enrollment until **November 18, 2014**.

- You may qualify for a waiver if you meet applicable eligibility criteria and (for example):
 - You are uninsured and did not intentionally forgo enrollment in health insurance; or
 - You applied for MassHealth or other subsidized coverage, and found out that you were denied after 63 days had passed; or
 - You lost insurance coverage but did not find out until after 63 days had passed
- You must first apply for coverage to a health insurance plan or agent and be turned down before you can apply for a waiver. You can apply for insurance on-line through the Health Connector at www.MAhealthconnector.org or by calling 877-MA-ENROLL. You can also apply to buy insurance directly through an insurance company or insurance agent.
- You may qualify for subsidized health insurance through the Health Connector or MassHealth. If you qualify, different enrollment rules apply and you might be able to enroll without a waiver. For example, a family of four with income of \$ 95,400 per year or less (about \$7,950 per month or less) may qualify for a subsidy. Go to MAhealthconnector.org for more information.
- You may not need a waiver if:
 - You lost insurance coverage recently (usually within the past 63 days); or
 - You are a small business owner buying insurance for your business; or
 - other reasons may apply
- You cannot get a waiver if you have or had health insurance coverage that you voluntarily terminated through not paying premiums or other actions, and have had no insurance for more than 63 days. You may be able to buy insurance during the next open enrollment period.

Please note that this form is not an application for health insurance. If your waiver request is approved, you must then complete the application process with the health insurance company or agent to which you originally applied. You will not have health insurance until your complete application is accepted and you pay your premium.

To apply for a waiver, you will need:

This completed Enrollment Waiver form; AND

A copy of the letter or notice denying your application to purchase health insurance

Please mail or fax your completed Enrollment Waiver form AND the notice denying your application to purchase health insurance to:

Health Policy Commission
Office of Patient Protection
Two Boylston Street, 6th Floor
Boston, MA 02116
Fax: 617-624-5046

Important Phone Numbers

- If you have questions about this form or the waiver process, please call the Office of Patient Protection (OPP) at 800-436-7757. You may also contact OPP by email at HPC-OPP@state.ma.us, but we cannot accept waiver applications by email. Do not send personal health information or other confidential information to OPP by email.
- If you have questions about open enrollment rules or your eligibility for health insurance, please call the Division of Insurance at 617-521-7794.
- If you have any questions about whether you qualify for health insurance, you can call the following places for information:
 - MassHealth, 800-841-2900
 - Health Care Division, Office of the Attorney General, 888-830-6277
 - The Health Connector, MAhealthconnector.org or 877-MA-ENROLL
 - Health Care For All, 800-272-4232

About Tax Penalty Waivers

If you are seeking a waiver of the tax penalty for being uninsured, do not use this form. Instead, contact:

- For state taxes, contact the Health Connector at 617-933-3164, and ask about the “Certificate of Exemption”
- For federal taxes, contact the federal Health Insurance Marketplace Call Center at 800-318-2596



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2014 REQUEST FOR WAIVER TO PURCHASE HEALTH INSURANCE

Please complete every question on this form and include any additional information you would like the Office of Patient Protection to consider. The Office of Patient Protection may call any of the persons listed on the form to verify the information or may ask you to provide additional information.

Please note that this form is not an application for health insurance. If your waiver request is approved, you must then complete the application process with the Health Connector, the health insurance company or agent to which you originally applied. You will not have health insurance until your complete application is accepted and you pay your premium.

1. Your Name	
2. Your full address (Please be sure to include city, state and zip code)	
3. How long have you been a Massachusetts resident?	
4. Email address	
5. Phone number	
6. Do you have insurance now or did you recently (within the past year) have health insurance?	_____ Yes _____ No If "yes" please provide the following information for the most recent plan: Type of plan: _____ nongroup _____ through an employer or other group (continued on next page)

<p>(Question 6, continued)</p>	<p>Name of health insurance company: _____</p> <p>Subscriber name: _____</p> <p>Relationship of subscriber to you: _____</p> <p>Date insurance ended: _____</p> <p>Reason insurance ended: _____</p> <p>_____</p>															
<p>7. Who do you want to include on the health plan?</p>	<p>___ Self only ___ Self and following family members:</p> <table border="0"> <thead> <tr> <th data-bbox="511 766 592 798">Name</th> <th data-bbox="722 766 885 798">Date of birth</th> <th data-bbox="974 766 1226 798">Relationship to you</th> </tr> </thead> <tbody> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> </tbody> </table> <p>Attach additional sheet if necessary for additional family members.</p>	Name	Date of birth	Relationship to you	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
Name	Date of birth	Relationship to you														
_____	_____	_____														
_____	_____	_____														
_____	_____	_____														
_____	_____	_____														
<p>8. Health insurance plan for which you are seeking a waiver.</p>	<p>Name of insurance company/plan: _____</p>															
<p>9. Did you receive a notice from the insurance company, the Health Connector or an agent telling you that you cannot enroll without a waiver?</p>	<p>___ Yes ___ No</p> <p>If yes, please enclose a copy with this request.</p> <p>If no, please note that you must first apply for coverage and be turned down before you submit this request.</p> <p>If you attempted to complete the Health Connector's on-line application and did not receive a denial notice by mail, then please print out the web page or email which says you do not qualify and include it with this application.</p>															

10. Please describe why you do not have insurance at this time, and why you should receive a waiver. For example --

- Explain why you did not buy insurance during the last open enrollment period
- If you lost your insurance, explain why and when you lost your health insurance coverage
- Explain why you did not buy new health insurance within 63 days of losing your prior health insurance

SIGNATURE AND CERTIFICATION

I _____, hereby request a waiver of the requirement that I wait until
(Print name)
the next open enrollment to purchase health insurance. I swear that the information provided in this
application is true and accurate to the best of my knowledge.

Signature of applicant Date: _____

I certify, under the penalty of perjury, that I did not intentionally forgo enrollment into coverage for
which I was eligible.

Signature of applicant Date: _____

WHAT TO SEND AND WHERE TO SEND IT

Mail the completed Request for Waiver form AND a copy of the letter or notice that told you that you
cannot enroll in health coverage without a waiver to:

**Health Policy Commission
Office of Patient Protection
Two Boylston Street, 6th Floor
Boston, MA 02116**

Or fax the completed Request for Waiver form and notice to **617-624-5046**.

Please send pages 3-6 of the Request for Waiver form. You do not need to send the instruction pages.

The Office of Patient Protection will respond to your request in writing within 30 days. You can reach
the Office of Patient Protection at 800-436-7757. You may also contact the Office of Patient Protection
by email at HPC-OPP@state.ma.us with questions, but we cannot accept waiver applications by email.
Do not send your Request for Waiver form or any personal health information to this email address.