

Timelines for Filing a Waiver:

You may file a Waiver Application at any time.

Enrollee Payment While Application is Pending:

The first time we receive your properly completed Waiver-Reduction Application, you will not be required to pay your premium until the Connector has issued a decision on your Application. If you submit a Waiver-Reduction Application after the Connector has denied an earlier Application, then you may be required to pay a premium while the Connector considers your subsequent Application.

If the Connector denies your Application, then you may be required to pay the premiums that accrued while you waited for a decision on your Application, in order to keep your health insurance coverage going forward.

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.

Designation of Representative:

You may designate someone as your Representative for purposes of completing this Application. To designate a Representative to receive information on your behalf regarding your Waiver-Reduction Application, you must submit a *Representative Form* that is signed by both you and/or your Representative. The Connector will only accept this Representative on the *Representative Form*. By designating this Representative, you are authorizing the Connector to share your personal health information with that Representative. To submit the *Representative Form*, call the Commonwealth Care Customer Service Center.

Assistance with this Form:

Please mail or fax this Application, proof of your hardship, and any other materials for us to consider. Please send photocopies of your proof as we will not return originals. Keep a copy for your records.

Commonwealth Care Customer Service Center
P.O. Box 120089 Boston, MA 02112-9914
1-877-MA-ENROLL Fax: 1-877-623-2155
Business Hours Monday-Friday 8am-5pm

If you need assistance in completing this Application, please contact the Commonwealth Care Customer Service Center. Please note that failure to properly complete this Application, or send it in on time if you have received notice of a pending disenrollment due to non-payment of premium, may prevent your Application from being accepted. Only Connector approved formats will be accepted.

SECTION IV: Proof of Hardship

You must 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 such as bills, receipts, or letters from your landlord, mortgage, and/or utility company. *You must include evidence for each box you check in Section II.*

SECTION V: Proof of Hardship Attachments

Please list each of the attachments that you are including with this Application. If you need more space, please attach a separate sheet:

SECTION VI: Waiver or Reduction Request

I am requesting a:

- Waiver of future premium
- Waiver of past due premium
- Reduction of future premium
- Reduction of past due premium.

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

SECTION VII: Length of Waiver or Reduction

It is the Connector's discretion, pursuant to our regulations, 956 CMR 3.11(5)(b) and (c), whether or not you will get a waiver or reduction. The maximum amount of time you could be granted a waiver is six months and it could be less.

SECTION VIII: 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 Connector and Connector contracted entities for the purpose of making a decision on my Waiver-Reduction Application.

Signature (Sign) _____ Date _____

First Name and Last Name (Print) _____

Check here if you are a Representative signing on behalf of the named individual. [If so, you must fill out the Representative Form to receive information.]

Send this to the Commonwealth Care Customer Service Center with your proof. Keep a copy for your records.