

# Application for Health Coverage

	<b>Apply faster and easier online by visiting <a href="http://VermontHealthConnect.gov">VermontHealthConnect.gov</a></b>
	<b>Reporting changes</b> If you have already applied for health coverage and simply need to report a change, <b>DO NOT</b> use this application, instead call <b>1-855-899-9600</b> .
	<b>Get help with costs</b> <b>You need to use a different application to get help with costs.</b> You could qualify for: <ul style="list-style-type: none"> <li>• A new tax credit that can immediately lower your premiums for health coverage</li> <li>• Free or low-cost coverage from Medicaid/Dr. Dynasaur</li> </ul> <b>You may qualify for a free or low-cost program even if you earn as much as \$94,000 a year (for a family of 4). Visit <a href="http://VermontHealthConnect.gov">VermontHealthConnect.gov</a> or call 1-855-899-9600 to learn more.</b>
	<b>Who can use this application?</b> <ul style="list-style-type: none"> <li>• If you do not need help to pay for your health coverage, you can use this application. <b>You will be responsible for the full cost.</b></li> <li>• If you are seeking dental coverage only, you can use this application.</li> <li>• If someone is helping you fill out this application, you may need to complete <b>Appendix A.</b></li> </ul>
	<b>What happens next?</b> Send your completed and signed application to the address on page 5. <b>(If you do not have all the information we ask for, sign and submit your application anyway.)</b> We will follow up with you within 1-2 weeks to let you know how to join a health plan. Filling out this application does not mean you have to buy health coverage.
	<b>Get help with this application</b> <ul style="list-style-type: none"> <li>• <b>Online:</b> <a href="http://VermontHealthConnect.gov">VermontHealthConnect.gov</a>.</li> <li>• <b>Phone:</b> Call our Help Center at <b>1-855-899-9600</b>.</li> <li>• <b>Relay services for the deaf:</b> Dial <b>711</b> (TTY and voice)</li> <li>• <b>In person:</b> There is someone who can help in your area. Call <b>1-855-899-9600</b>.</li> <li>• <b>Find a navigator or broker:</b> Call <b>1-855-554-4488</b>, or visit the website at <a href="http://VermontHealthConnect.gov">VermontHealthConnect.gov</a>.</li> </ul>
	<b>If you need interpretation services...</b> (Arabic) 1-855-899-9600 إذا أنت ترغب خدمات الترجمة الفورية اتصل برقم Ako su Vam potrebne usluge tumačenja, pozovite 1-855-899-9600. (Bosnian) စကားပြန် ဝန်ဆောင်မှုလုပ်ငန်းကိုအလိုရှိပါက 1-855-899-9600 သို့ ဖုန်းဆက်ခေါ်ပါ။ (Burmese) Si vous avez besoin de services d'interprétation, appelez le 1-855-899-9600. (French) Mugihe woba ushaka impfashanyo yo gusigurirwa, hamagara uyu murongo 1-855-899-9600. (Kirundi) यदि तपाईंलाई दोभाषे सेवाको जरुरत परेमा, 1-855-899-9600 मा कल गर्नुहोस्। (Nepali) Haddii aad u baahan tahay adeegyo turjumaan, wac 1-855-899-9600. (Somali) Si usted necesita servicios de interpretación, llame al 1-855-899-9600. (Spanish) Ikiwa unahitaji huduma za ukalimani, piga simu 1-855-899-9600. (Swahili) Nếu quý vị cần dịch vụ thông ngôn, hãy gọi 1-855-899-9600. (Vietnamese)

**You may keep this page for future reference. Your Rights and Responsibilities are on the back of this page. Be sure to read through them. If you need help understanding something, contact Vermont Health Connect at 1-855-899-9600.**

# Your Rights and Responsibilities

We need the information we asked for to decide if you qualify for health coverage if you choose to apply. We may check your answers using information from the Social Security Administration, the Department of Homeland Security, and/or a consumer reporting agency. If the information does not match, we may ask you to send us proof.

**Social Security Numbers.** All individuals applying for health benefits who have a Social Security number (SSN) must provide them. Vermont Health Connect uses SSN for computer processing, child support enforcement, fraud investigation, audits, and Lifeline identification; to verify Social Security and Supplemental Security income (SSI); to prevent individuals from receiving duplicate benefits; to exchange information with agencies such as the Social Security Administration, Department of Labor, or private agencies to verify income, determine eligibility and benefits amounts, and collect claims; to determine the accuracy and reliability of information given to Vermont Health Connect; and to make medical assistance payments.

A person who is not seeking coverage does not need to provide a Social Security number. If you are a member of a religious organization that objects to furnishing an SSN, the Agency of Human Services may disregard this requirement. This requirement does not apply to an individual who: Is not eligible to receive an SSN or does not have an SSN and may only be issued an SSN for a valid non-work reason in accordance with 20 CFR 422.104. The state will assign an identification number to these individuals.

**Quality Control.** Vermont Health Connect may select your application for a quality control review. By signing your application, you agree to give proof of required information. If you are not able to give the proof needed, you are authorizing Vermont Health Connect to get it.

**Confidentiality.** Your confidential information is protected as required by federal and state laws and regulations. The use and disclosure of information concerning applicants, enrollees, and legally-liable third parties is restricted to purposes directly connected with the administration of programs, or as otherwise required by law.

**Information Sharing.** By signing your application you give Vermont Health Connect permission to share information about you to assist you with program enrollment. Your permission covers the following kinds of information:

- Information or proofs needed to complete your application.
- The status of your application including the program(s) you are enrolled in and the effective date of enrollment.
- The reason you are not eligible for a benefit, if your application is denied or your benefits end.
- The effective date(s) of your renewal(s) for benefits and any outstanding information or verifications needed to assist your renewal.

**Timely Eligibility Determination.** Vermont Health Connect must make a decision on your application no later than 30 days after your application date unless delay is caused by an unexpected emergency or administrative problem beyond the Department's control, or yours. **If you do not get a decision within 30 days**, you may call Vermont Health Connect at **1-855-899-9600** for more information or to request a fair hearing.

**Your Right to Appeal.** If you think Vermont Health Connect has made a mistake, you can appeal its decision. To appeal means to tell someone at Vermont Health Connect that you think the action is wrong, and ask for a fair review of the action. Contact Vermont Health Connect at **1-855-899-9600**, or Health Care Advocate at Vermont Legal Aid at **1-800-917-7787** to find out how to appeal. You can be represented in the process by someone other than yourself. Eligibility and other important information will be explained to you when you call Vermont Health Connect.

**Complaints, Grievances, and Appeals.** The Agency of Human Services offers several ways to address dissatisfaction with our programs and resulting eligibility decisions. A **"complaint"** is about a general process or program or personnel; there is no formal response back to the individual. A **"grievance"** is usually about an issue or incident within the last 60 days that is not about covered services, authorized services or eligibility. A response is usually provided within 90 days. An **"appeal"** is usually a request to review a recent decision that denied, terminated, or reduced services. An appeal can also be expedited if the individual feels waiting would cause them harm.

Please be aware there is no right to a fair hearing when either state or federal law requires automatic case adjustments for classes of enrollees, unless the reason for an individual fair hearing is incorrect eligibility determination. These case adjustments are called **"mass changes."**



## STEP 1

### PERSON 1: Tell us about yourself

The adult listed here will be considered the “applicant” and primary contact for this household’s application.

1. First name, middle name, last name & suffix (Jr., Sr., III, etc.)

2. List any other names you have been known by, including a maiden name or alias.

3. Home address (leave blank if you do not have one)

4. Apartment or suite number

5. City

6. State

7. ZIP code

8. County

9. Mailing address line 1 (if different from home address)

10. Apartment or suite number

11. Mailing address line 2 (if applicable, include an “in-care-of” person here. For an Authorized Representative, complete **Appendix A.**)

12. City

13. State

14. ZIP code

15. County

16. HOME phone number  
( ) -

17. WORK phone number  
( ) -

18. CELL phone number  
( ) -

19. Marital status:  Married  Civil Union  Never married  Separated  Divorced/dissolved  Widowed  
If you are a victim of domestic violence and applying separately from your spouse, you may indicate that you are “Never married”.

20. What is your preferred spoken or written language (if not English)?

21. Are you applying for health coverage for yourself?  Yes  No

22. Social Security number \_ \_ \_ - \_ \_ - \_ \_ \_

**We need Social Security Numbers (SSNs)** for anyone who wants coverage. We use SSNs to verify citizenship. If someone does not have an SSN, visit [socialsecurity.gov](http://socialsecurity.gov) or call **1-800-772-1213**. TTY users should call **1-800-325-0778**.

23. Sex  Male  Female

24. Date of birth (mm/dd/yyyy)

\_ \_ / \_ \_ / \_ \_ \_ \_

25. Are you a U.S. citizen or U.S. national?  Yes  No

26. **If you are not a U.S. citizen or U.S. national**, do you have eligible immigration status?

**YES**. Fill in your document information below.

- a. Immigration document type \_\_\_\_\_ d. Passport or document number \_\_\_\_\_  None  
 b. Document expiration date \_\_\_\_\_  None e. Country of origin \_\_\_\_\_  
 c. Alien number \_\_\_\_\_ f. Category code \_\_\_\_\_

27. **If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)**

Mexican  Mexican American  Chicano/a  Puerto Rican  Cuban  Other \_\_\_\_\_

28. **Race (OPTIONAL—check all that apply.)**

- White  American Indian or Alaska Native  Filipino  Vietnamese  Guamanian or Chamorro  
 Black or African American  Asian Indian  Korean  Other Asian  Samoan  
 Chinese  Native Hawaiian  Other Pacific Islander  Other \_\_\_\_\_

**Now, tell us who else needs health coverage.** 

 **NEED HELP WITH YOUR APPLICATION?** Visit [VermontHealthConnect.gov](http://VermontHealthConnect.gov) or call toll-free **1-855-899-9600**. Relay services for the deaf **711**.

# STEP 2

## Tell us about anyone who needs health coverage

If you have more than 3 members in your household, copy this page before you fill it out. You should also include your name and SSN at the top of all copied page(s).

### STEP 2: PERSON 2

1. First name, middle name, last name & suffix (Jr., Sr., III, etc.)		2. Relationship to you?		
3. List any other names PERSON 2 has been known by (e.g., maiden name or alias)		4. Date of birth (mm/dd/yyyy) ____/____/____	5. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	
6. Social Security number ____-____-____	7. Marital status: <input type="checkbox"/> Married <input type="checkbox"/> Civil Union <input type="checkbox"/> Never married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced/dissolved <input type="checkbox"/> Widowed			
8. Does PERSON 2 live at the same address as you? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If no</b> , list address:				
9. Do you want health coverage for PERSON 2? <input type="checkbox"/> Yes <input type="checkbox"/> No		10. Is PERSON 2 a U.S. citizen or U.S. national? <input type="checkbox"/> Yes <input type="checkbox"/> No		
11. <b>If PERSON 2 is not a U.S. citizen or U.S. national</b> , do they have eligible immigration status?				
<input type="checkbox"/> <b>YES</b> . Fill in PERSON 2's document information below.				
a. Immigration document type _____		d. Passport or document number _____ <input type="checkbox"/> None		
b. Document expiration date _____ <input type="checkbox"/> None		e. Country of origin _____		
c. Alien number _____		f. Category code _____		
12. <b>If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)</b>				
<input type="checkbox"/> Mexican <input type="checkbox"/> Mexican American <input type="checkbox"/> Chicano/a <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Cuban <input type="checkbox"/> Other _____				
13. <b>Race (OPTIONAL—check all that apply.)</b>				
<input type="checkbox"/> White	<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Filipino	<input type="checkbox"/> Vietnamese	<input type="checkbox"/> Guamanian or Chamorro
<input type="checkbox"/> Black or African American	<input type="checkbox"/> Asian Indian	<input type="checkbox"/> Japanese	<input type="checkbox"/> Other Asian	<input type="checkbox"/> Samoan
<input type="checkbox"/> Chinese	<input type="checkbox"/> Korean	<input type="checkbox"/> Native Hawaiian	<input type="checkbox"/> Other Pacific Islander	<input type="checkbox"/> Other _____

### STEP 2: PERSON 3

1. First name, middle name, last name & suffix (Jr., Sr., III, etc.)		2. Relationship to you?		
3. List any other names PERSON 3 has been known by (e.g., maiden name or alias)		4. Date of birth (mm/dd/yyyy) ____/____/____	5. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	
6. Social Security number ____-____-____	7. Marital status: <input type="checkbox"/> Married <input type="checkbox"/> Civil Union <input type="checkbox"/> Never married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced/dissolved <input type="checkbox"/> Widowed			
8. Does PERSON 3 live at the same address as you? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If no</b> , list address:				
9. Do you want health coverage for PERSON 3? <input type="checkbox"/> Yes <input type="checkbox"/> No		10. Is PERSON 3 a U.S. citizen or U.S. national? <input type="checkbox"/> Yes <input type="checkbox"/> No		
11. <b>If PERSON 3 is not a U.S. citizen or U.S. national</b> , do they have eligible immigration status?				
<input type="checkbox"/> <b>YES</b> . Fill in PERSON 3's document information below.				
a. Immigration document type _____		d. Passport or document number _____ <input type="checkbox"/> None		
b. Document expiration date _____ <input type="checkbox"/> None		e. Country of origin _____		
c. Alien number _____		f. Category code _____		
12. <b>If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)</b>				
<input type="checkbox"/> Mexican <input type="checkbox"/> Mexican American <input type="checkbox"/> Chicano/a <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Cuban <input type="checkbox"/> Other _____				
13. <b>Race (OPTIONAL—check all that apply.)</b>				
<input type="checkbox"/> White	<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Filipino	<input type="checkbox"/> Vietnamese	<input type="checkbox"/> Guamanian or Chamorro
<input type="checkbox"/> Black or African American	<input type="checkbox"/> Asian Indian	<input type="checkbox"/> Japanese	<input type="checkbox"/> Other Asian	<input type="checkbox"/> Samoan
<input type="checkbox"/> Chinese	<input type="checkbox"/> Korean	<input type="checkbox"/> Native Hawaiian	<input type="checkbox"/> Other Pacific Islander	<input type="checkbox"/> Other _____

## STEP 3 Household Special Circumstances

The questions below are about life events that may have happened in your household in the past 60 days. Your answers will help us determine if you, or other household members, can enroll in a private health plan outside of an open enrollment period. A representative may contact you for additional information about your situation to determine if you or other household members qualify for a Special Enrollment Period (SEP). **Please note there is no open enrollment period for Medicaid/Dr. Dynasaur coverage. You may apply for Medicaid/Dr. Dynasaur at any time. To apply for Medicaid/Dr. Dynasaur, you need a different application called "Application for Health Coverage and Help Paying Costs."**

1. Did anyone on this application lose health coverage in the past 60 days (including employer-sponsored coverage or Medicaid/Dr. Dynasaur)?  Yes  No  
Who? \_\_\_\_\_ Date coverage ended: \_\_\_\_\_
2. Has anyone joined your household through an adoption in the past 60 days?  Yes  No  
Who? \_\_\_\_\_ Date adoption was finalized: \_\_\_\_\_
3. Has anyone joined your household through the foster care program in the past 60 days?  Yes  No  
Who? \_\_\_\_\_ Date child joined your household: \_\_\_\_\_
4. Did anyone on this application gain U.S. citizenship, eligible immigration status, or become lawfully present in the past 60 days?  Yes  No  
Who? \_\_\_\_\_ Date of change to status: \_\_\_\_\_
5. Did anyone on this application move to Vermont in the past 60 days?  Yes  No  
Who? \_\_\_\_\_ Date arrived in Vermont: \_\_\_\_\_
6. Did anyone on this application get released from incarceration (jail or prison) in the past 60 days?  Yes  No  
Who? \_\_\_\_\_ Date of release: \_\_\_\_\_
7. Has anyone gained a dependent through marriage or birth in the past 60 days?  Yes  No  
Who? \_\_\_\_\_ Date of marriage and/or birth: \_\_\_\_\_
8. Has anyone in the household become newly eligible or newly ineligible for an Individual Exemption to purchase a Catastrophic Plan in the past 60 days?  Yes  No  
Who? \_\_\_\_\_ Date of eligibility or *ineligibility*: \_\_\_\_\_
9. Has any household member's employer-sponsored insurance become unaffordable due to a decrease in their job income or had their work hours decreased in the past 60 days?  Yes  No  
Who? \_\_\_\_\_ Date of income decrease: \_\_\_\_\_
10. In the past 60 days, has anyone in your household become eligible for employer-sponsored health coverage but is in a waiting period before they can enroll?  Yes  No  
Who? \_\_\_\_\_ Date waiting period ends: \_\_\_\_\_
11. Has any parent in your household been required by a court or administrative order to provide health insurance for a dependent child in the past 60 days?  Yes  No  
Who? \_\_\_\_\_
12. Have there been any other changes in your household or circumstances in the past 60 days that you feel should be considered when making a decision about any household member's eligibility for a Special Enrollment Period? If so, please explain:  Yes  No  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## STEP 4

### American Indian or Alaska Native family member(s)

1. **Are you, or anyone in your family, an American Indian with a federally recognized tribe or an Alaska Native?**

**No.** If no, skip to Step 5.

**Yes.** If yes, continue. If you have more people to include, make a copy of this page and attach.

	PERSON 1		PERSON 2	
2. First, middle, last name & suffix (Jr., Sr., III, etc.)	First	Middle	First	Middle
	Last		Last	
3. Alaska Native?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Member of a federally recognized tribe?	<input type="checkbox"/> Yes If yes, tribe name: _____ State where recognized: _____ <input type="checkbox"/> No	<input type="checkbox"/> Yes If yes, tribe name: _____ State where recognized: _____ <input type="checkbox"/> No	<input type="checkbox"/> Yes If yes, tribe name: _____ State where recognized: _____ <input type="checkbox"/> No	<input type="checkbox"/> Yes If yes, tribe name: _____ State where recognized: _____ <input type="checkbox"/> No

## STEP 5

### Read your rights and responsibilities

- I know that I must tell Vermont Health Connect if anything changes or is different than what I wrote on this application. I can visit **VermontHealthConnect.gov** or call **1-855-899-9600** to report any changes. I understand that a change in my information could affect the eligibility for the member(s) of my household.
- I know that the information on this form will only be used to determine eligibility for health coverage and will be kept private as required by state and federal law.
- I know that under federal law, discrimination is not permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting **www.hhs.gov/ocr/office/file**.
- I confirm that no one applying for health insurance on this application is incarcerated (detained or jailed). If not, I now indicate \_\_\_\_\_ is incarcerated.  
(name of incarcerated person)
- If I think Vermont Health Connect has made a mistake, I can appeal its decision. To appeal means to tell someone at Vermont Health Connect that I think the action is wrong, and ask for a fair review of the action. I understand that I can find out how to appeal by contacting Vermont Health Connect at **1-855-899-9600**, or Health Care Advocate at Vermont Legal Aid at **1-800-917-7787**.



**NEED HELP WITH YOUR APPLICATION?** Visit **VermontHealthConnect.gov** or call toll-free **1-855-899-9600**. Relay services for the deaf **711**.

## STEP 6

### Sign this application

**You MUST sign below. Unsigned applications will not be processed and will be returned for a signature.**

The person listed in Step 1 (the applicant) should sign this application. If they cannot, and you are their Authorized Representative, you may sign for them, as long as you have provided the information required in **Appendix A**. If signing on behalf of a minor child or an incapacitated adult, you may do so as long as you provide your personal information below as well.

**Not signing the application may delay health coverage.**

**By signing this application, the applicant agrees to the following:**

- I have read and understand my rights and responsibilities as they are described on pages ii and 4 of this application.
- I am signing this application under penalty of perjury, which means I have provided true answers to all the questions on this form to the best of my knowledge. I know that I may be subject to penalties under federal law if I provide false and/or untrue information.

**By signing this application *on behalf of* the applicant, a person *other than* the applicant agrees to the following:**

- I am acting to provide information to establish and maintain eligibility for healthcare benefits for the applicant. This is because the applicant is a minor child or has a physical or mental condition that prevents him or her from providing information about his or her situation and acting responsibly in his or her own behalf.
- I will provide information to the best of my knowledge concerning the applicant's situation.
- I understand that if I knowingly withhold any information or knowingly misrepresent the facts, I may be prosecuted for perjury or fraud. I agree to notify Vermont Health Connect immediately if I learn of any change in the applicant's situation.

**If you are signing on behalf of the applicant because they are a minor child or incapacitated adult, please also provide the information requested below, in case we need to reach you about the application. If you are signing as an Authorized Representative, you must fill out Appendix A.**

Person signing on behalf of the applicant (first, middle, last name & suffix (Jr., Sr., III, etc.))

Agency name (If applicable)		Phone number (      )      -	
Street address/PO Box	City	State	ZIP code

<b>Signature</b> (applicant, or person signing on behalf of applicant)	<b>Date (mm/dd/yyyy)</b>
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**Voter Registration.** If you are not registered to vote where you live now, would you like a voter registration application?  Yes  No  
If you do not check either box, we will assume you have decided not to register to vote at this time. Answering Yes or No here will not affect your eligibility for health coverage.

## STEP 7

### Mail the completed and signed application to:

**Vermont Health Connect  
103 South Main Street  
Waterbury, VT 05671-8100**

#### PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1191. The time required to complete this information collection is estimated to average 20 minutes per application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.



**NEED HELP WITH YOUR APPLICATION?** Visit [VermontHealthConnect.gov](http://VermontHealthConnect.gov) or call toll-free **1-855-899-9600**. Relay services for the deaf **711**.

# APPENDIX A

## Assistance Completing the Application

### APPLICANT Information

Applicant first name, middle name, last name & suffix (Jr., Sr., III, etc.)	Applicant Social Security number ____ - ____ - _____
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**You can choose an AUTHORIZED REPRESENTATIVE.**

You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an Authorized Representative. If you are a legally appointed representative for someone on the application (power of attorney, legal guardian) submit proof with this form.

1. Name of Authorized Representative (first name, middle name, last name & suffix (Jr., Sr., III, etc.))		
2. Address	3. Apartment or suite number	
4. City	5. State	6. ZIP code
7. Phone number (       ) -       -		
8. Organization name	9. ID number (if applicable)	
By signing, you allow this person to sign your application, get official information about the application, and act for you on all future matters with this agency.		
10. Your signature	11. Date (mm/dd/yyyy)	

**You can choose an ALTERNATE REPORTER.**

You can give a trusted person permission to only get copies of notices about your application and about coverages for yourself and others on the application. This person is called an Alternate Reporter. An Alternate Reporter cannot act for you or report changes for you, but they can help you understand the notices or remind you if we ask you for information. An Alternate Reporter can also be an Authorized Representative.

1. Name of Alternate Reporter (first name, middle name, last name & suffix (Jr., Sr., III, etc.))		
2. Address	3. Apartment or suite number	
4. City	5. State	6. ZIP code
7. Phone number (       ) -       -		
8. Organization name	9. ID number (if applicable)	
By signing, you allow this person to only receive copies of notices about your coverage and the coverage for others on the application and all future matters with this agency.		
10. Your signature	11. Date (mm/dd/yyyy)	

**If you want to change your Authorized Representative or Alternate Reporter, contact Vermont Health Connect at 1-855-899-9600.**

**For certified application counselors, navigators, and brokers only.**

Complete this section if you are a certified application counselor, navigator, or broker filling out this application for somebody else.

1. Application start date (mm/dd/yyyy)	
2. First name, middle name, last name & suffix (Jr., Sr., III, etc.)	
3. Organization name	4. ID number (if applicable)