Tribal Premium Sponsorship Program

2018 Marketplace Application

Applicant Information

Full Legal Name: _____
First *Last* *M.I.*

Address: _____
P.O. Box

_____
City *State* *ZIP Code*

Date of Birth: _____ Social Security Number: _____

Home Phone: _____ Do you smoke tobacco? ☐ Yes ☐ No

Create Marketplace Account:

Email address: _____

Create password for Marketplace: _____

What is your favorite radio station? _____

What is your favorite food? _____

What is the name of your favorite pet? _____

Income Information

Name of Employer: _____

_____
Hours per week *Hourly pay* *Annually*

Do you receive alimony? ☐ Yes, $_____ ☐ No

Do you pay on student loans? ☐ Yes, $_____ ☐ No

Do you receive per cap? ☐ Yes, $_____ ☐ No

Do you receive payments from natural resources, farming, ranching, fishing, or leasing land designated as Indian land?

☐ Yes, $_____ ☐ No

Background Information

Tax dependent(s) seeking coverage? *(Do not include yourself)*

1 _____
Full Legal Name *D.O.B.*

_____
Social Security Number *Tribal Affiliation*

2 _____
Full Legal Name *D.O.B.*

_____
Social Security Number *Tribal Affiliation*

3 _____
Full Legal Name *D.O.B.*

_____
Social Security Number *Tribal Affiliation*

| P: 406-477-4997 OR 406-477-4921| F: 406-477-6829 |
| 100 EAGLE FEATHERS ST LAME DEER, MT 59043 |

Are you currently eligible or offered health coverage through a job? *(Through a spouse or parent)*

☐ Yes ☐ No

Tribal affiliation *(Federally recognized)*

☐ Northern Cheyenne ☐ Turtle Mountain ☐ Apache
☐ Crow ☐ Navajo ☐ Other _____

Do you plan to file a federal income tax for 2018?

☐ Yes ☐ No

How many dependents will you claim on your taxes? *(Do not include yourself)*

_____ dependents

Are you married? *(If so, you will need to file taxes jointly)*

☐ Yes ☐ No

Any household members in foster care or adopted?

☐ Yes, _____ ☐ No

Any household members seeking coverage need help with daily activities (help getting dressed, help eat), or live in a nursing home? (If yes, who?)

☐ Yes, _____ ☐ No

Do you, or any of your dependents, receive any of the following?

☐ Medicaid ☐ TRICARE ☐ Private insurance
☐ CHIP ☐ VA ☐ None
☐ Medicare ☐ Peace Corps

Was anyone in your household been denied coverage through Medicaid or Montana Health Kids?

☐ Yes, _____ ☐ No

Important to Remember

☐ I ***must*** utilize IHS (Secure a referral from NC IHS before going to Billings or elsewhere) except for emergencies.

☐ Dental and vision premiums are ***not*** covered by TPSP; I ***must*** pay my own dental or vision premiums.

☐ I ***must*** report any life changes (income, tax dependents, employer, household size) to TPSP.

☐ I ***must*** file taxes. You will get a 1095-A from TPSP/IRS.

☐ I ***must*** provide a copy of my Blue Cross Blue Shield Card to TPSP once enrolled.

I agree to and understand the information provided in this section by a member of TPSP.

Signature: _____ Date: _____

TPSP Team Member: _____ Date: _____