STEP 2: ADDITIONAL PERSON

Name from STEP 1 _____

COVER VIRGINIA
Connecting Virginians to Affordable Health Insurance

Complete Step 2 for your spouse and children who live with you and/or anyone on your same federal income tax return if you file one. Include both parents living in the home (for a child under 21). See page 1 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

1. First name, Middle name, Last name, & Suffix

2. Relationship to you?

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

4. Sex ☐ Male ☐ Female

5. Social Security number (SSN) ___ ___ ___ - ___ ___ - ___ ___ ___ ___
We need this if you want health coverage and have an SSN.

6. Does this PERSON live at the same address as you? ☐ Yes ☐ No
If no, list address: _____

7. **Does this PERSON plan to file a federal income tax return NEXT YEAR?**
(You can still apply for health insurance even if you don't file a federal income tax return.)

☐ **YES. If yes,** please answer questions a–c. ☐ **NO. If no,** skip to question c.

a. Will this PERSON file jointly with a spouse? ☐ Yes ☐ No
If yes, name of spouse: _____

b. Will this PERSON claim any dependents on his or her tax return? ☐ Yes ☐ No
If yes, list name(s) of dependents: _____

c. Will this PERSON be claimed as a dependent on someone's tax return? ☐ Yes ☐ No
If yes, please list the name of the tax filer: _____
How is this PERSON related to the tax filer? _____

8. Is this PERSON pregnant? ☐ Yes ☐ No a. **If yes,** how many babies are expected during this pregnancy? _____ Expected due date: _____

9. **Does this PERSON need health coverage?** *(Even if they have Medicare or other insurance, there might be a program with better coverage or lower costs.)* **If NO, skip to the income questions on the next page and leave the rest of this page blank.**

☐ **YES. If yes**, answer all the questions below.

☐ **YES.** If under 19 or over 64 and not eligible for full coverage, do you wish to be evaluated for Plan First (family planning coverage only)?

or

☐ **NO.** If you are age 19 to 64 and are not eligible for full coverage, you will be evaluated for Plan First (family planning coverage only) unless you check NO.

10. Does this PERSON have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc) or live in a medical facility or nursing home? If Yes, please complete Appendix D. ☐ Yes ☐ No

11. Is this PERSON a U.S. citizen or U.S. national? ☐ Yes ☐ No

12. **If this PERSON isn't a U.S. citizen or U.S. national,** do they have eligible immigration status?
☐ Yes. Fill in their document type and ID number below.
a. Document type _____ b. Document ID number _____
c. Has this PERSON lived in the U.S. since 1996? ☐ Yes ☐ No d. Is this PERSON, or their spouse or parent a veteran or an active-duty member in the U.S. military? ☐ Yes ☐ No

13. Is this Person living with at least one child under age 19 and the main person taking care of this child? ☐

14. Was this PERSON in foster care in Virginia at age 18 or older?
☐ Yes ☐ No

Please answer the following questions if this PERSON is 18 or younger:

15. Did this PERSON have insurance that ended within the past 4 months? ☐ Yes ☐ No
a. **If yes**, end date: _____ b. Reason the insurance ended: _____

*For a list of reasons, please see page 6.

16. Is this PERSON a full-time student? ☐ Yes ☐ No

17. **If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)**
☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

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

☐ White	☐ American Indian or Alaska Native	☐ Filipino	☐ Vietnamese	☐ Guamanian or Chamorro
☐ Black or African American	☐ Asian Indian	☐ Japanese	☐ Other Asian	☐ Samoan
	☐ Chinese	☐ Korean	☐ Native Hawaiian	☐ Other Pacific Islander
				☐ Other _____

Now, tell us about any income from this PERSON on the back.

NEED HELP WITH YOUR APPLICATION? Visit the Cover Virginia website at **coverva.org** or call us at **1-855-242-8282**. Para obtener una copia de este formulario en Español, llame **1-855-242-8282**. If you need help in a language other than English, call **1-855-242-8282** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-888-221-1590**.

STEP 2: ADDITIONAL PERSON

Current Job & Income Information

☐ **Employed**
If this PERSON is currently employed, tell us about their income. Start with question 19.

☐ **Not employed**
Skip to question 29.

☐ **Self-employed**
Skip to question 28.

CURRENT JOB 1:

19. Employer name and address

20. Employer phone number
( ) –

21. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

$ _____

22. Average hours worked each WEEK

CURRENT JOB 2: (If they have more jobs and need more space, attach another sheet of paper.)

23. Employer name and address

24. Employer phone number
( ) –

25. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

$ _____

26. Average hours worked each WEEK

27. **In the past year, did this PERSON:** ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

28. **If self-employed, answer the following questions:**

a. Type of work _____

b. How much net income (profits once business expenses are paid) will this person get from this self-employment this month? $ _____

29. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often they get it.

NOTE: You don't need to tell us about child support, veteran's payment, or Supplemental Security Income (SSI).

☐ None

☐ Unemployment $ _____ How often? _____

☐ Pensions $ _____ How often? _____

☐ Social Security $ _____ How often? _____

☐ Retirement accounts $ _____ How often? _____

☐ Alimony received $ _____ How often? _____

☐ Net farming/fishing $ _____ How often? _____

☐ Net rental/royalty $ _____ How often? _____

☐ Other income $ _____ How often? _____
Type: _____

30. Does this PERSON want help paying for medical bills from the last 3 months? ☐ Yes ☐ No If yes, provide monthly income for the last 3 months. Month 1: $ _____ Month 2: $ _____ Month 3: $ _____

31. **DEDUCTIONS:** Check all that apply, and give the amount and how often they get it.

If this PERSON pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.

NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment (question 28b).

☐ Alimony paid $ _____ How often? _____

☐ Student loan interest $ _____ How often? _____

☐ Other deductions $ _____ How often? _____
Type: _____

32. **YEARLY INCOME: Complete only if this PERSON's income changes from month to month.**

If you don't expect changes to this PERSON's monthly income, add another person or skip to the next section.

This PERSON's total income **this year**	This PERSON's total income **next year** (if you think it will be different)
$	$

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