

# APPLICATION FOR Health Care Coverage

*(and to find out if you can get help with costs)*

<p>Use this application to see what health care coverage you qualify for:</p>	<ul style="list-style-type: none"> <li>• Private Qualified Health Plans</li> <li>• To see if you qualify for financial assistance to help pay for coverage, use the longer form of this application.</li> </ul>
<p>Apply faster online</p>	<p>Apply faster online at <a href="http://www.healthsourceri.com">www.healthsourceri.com</a></p>
<p>Information you may need to apply:</p>	<ul style="list-style-type: none"> <li>• Social Security numbers</li> <li>• Birth dates</li> <li>• Passport, alien, or other immigration numbers for any legal immigrants who need health care coverage</li> </ul>
<p>Why do we ask for so much information?</p>	<p>We need the following information in order to determine what health care coverage you are qualified for. We will keep the information you provide private as required by law.</p>
<p>Send your complete and signed application to:</p>	<p>HealthSource RI HZD Mailroom 74 West Road, Suite 900 Cranston, RI 02920-8413</p>
<p>Get help with this application:</p>	<ul style="list-style-type: none"> <li>• Online: <a href="http://www.healthsourceri.com">www.healthsourceri.com</a></li> <li>• Phone: Call the Customer Support Center at 1-855-609-3304 or 1-888-657-3173 (TTY)</li> <li>• In person: To find in-person application assistance visit <a href="http://www.healthsourceri.com">www.healthsourceri.com</a>, <a href="http://www.dhs.ri.gov">www.dhs.ri.gov</a> or <a href="http://www.ohhs.ri.gov">www.ohhs.ri.gov</a> or visit 70 Royal Little Drive, Providence RI (Monday through Saturday 8:00 AM to 9:00 PM, Sundays 12:00 PM Noon to 6:00 PM)</li> </ul>

## Definitions

**HealthSource RI:** HealthSource RI is the Rhode Island health benefits exchange. It is a new way for individuals, families and small businesses in Rhode Island to compare and enroll in health coverage and gain access to tax credits, and reduced cost-sharing. HealthSource RI can also provide information about and assistance with applications for public programs such as Rhode Island Medical Assistance. You have access to HealthSource RI online, by phone, or in person.

**Premium:** A premium is the amount you pay every month for your health insurance, whether you're healthy or sick.

**QHP:** QHP stands for Qualified Health Plan. That means it meets Rhode Island's standards for health insurance. All plans must cover doctor visits, hospital stays, prescriptions and mental health care.

**Deductible:** A deductible is the amount you owe for certain health care services before your health insurance begins to pay. For example, if your deductible is \$1,000, and you need knee surgery, you pay the first \$1,000 of the bill. After that, your health plan starts paying for the cost of your care.

**APTC:** APTC stands for Advance Premium Tax Credit. Depending on your income, you may be eligible for a federal tax credit to help with the cost of your health insurance premium. Instead of waiting to claim the credit when you file your taxes, you can take the credit "in advance" each month to help pay your monthly premium. An Advance Premium Tax Credit is paid directly to your insurance provider. **Use the longer form of this application to see if you qualify.**

**Cost-Sharing Reductions:** Some Rhode Islanders will qualify for Cost-Sharing Reductions. These help you pay for the cost of going to the doctor or getting a health care service. **Use the longer form of this application to see if you qualify.**

**Minimum Essential Coverage:** This is the type of coverage an individual needs to have to meet the individual responsibility requirement under the Affordable Care Act. This includes individual market policies, job-based coverage, Medicare, Medicaid, Children's Health Insurance Plan (CHIP), TRICARE and other coverage that covers Essential Health Benefits.

**Minimum Value Standard:** A health plan meets the "minimum value standard" if the plan's share of the total benefit costs covered is no less than 60 percent of such costs. If you do not have access to any health coverage that meets the minimum value standard, you may be eligible for tax credits to help cover the cost of insurance. **Use the longer form of this application to see if you qualify.**

**Individual Responsibility Requirement:** Starting in 2014, the individual shared responsibility requirement calls for each individual to have minimum essential health coverage (known as minimum essential coverage) for each month, qualify for an exemption, or make a payment when filing his or her federal income tax return.

**Rhode Island Medical Assistance:** Public health coverage programs for eligible Rhode Island residents. Rhode Island Medical Assistance is the name used in Rhode Island for Medicaid, the Children's Health Insurance Program (CHIP) and state-only funded health care programs. **Use the longer form of this application to see if you qualify.**

# Health Care Coverage Rights and Responsibilities

## **Your rights for all health insurance programs. HealthSource RI must:**

**Help you fill out all requested forms.** You can contact HealthSource RI for assistance.

**Provide interpreter or translator services** at no cost to you when communicating with HealthSource RI.

**Keep your personal information private** but we may share some facts with other state and federal agencies for purposes of verification and enrollment.

In accordance with federal and state law and U.S. Department of Health and Human Services (HHS) policy, **this institution is prohibited from discrimination on the basis of race, color, national origin (limited English proficiency persons), age, sex, disability, religion, gender identity or political beliefs.** To file a complaint of discrimination, contact HHS. Write HHS, Director, Office for Civil Rights, Room 506-F, 200 Independence Avenue, S.W., Washington D.C. 20201 or call (202) 619-0403 (voice) or (202) 619-3257 (TDD). HHS is an equal opportunity provider and employer.

## **Your responsibilities for all health insurance programs. You must:**

**SSN Disclosure.** You must provide the Social Security number (SSN) for anyone in your household, including yourself, who has an SSN and applies for health insurance through HealthSource RI, under Federal Law (45 CFR 155.305).

SSNs are used to check identity, citizenship, alien status and income as well as prevent fraud and verify health care claims. We also use SSN information with other federal and state agencies, including the Internal Revenue Service, to manage our programs and follow the law.

**If requested by the agency,** provide any information or proof needed to decide if you are eligible.

**Report changes in income, family size or other application information** as soon as possible.

## **Things you should know for all health insurance programs:**

**There are certain state and federal laws** that govern the operation of HealthSource RI, your rights and responsibilities as a user of HealthSource RI, and the coverage obtained through HealthSource RI. By filling out this application, you agree to comply with these laws and coverage obtained hereby.

**The National Voter Registration Act of 1973** requires all states to provide voter registration assistance through their public assistance offices. Applying to register or declining to register to vote will not affect the services or benefits that you will be provided by this agency. You can register to vote at <http://www.elections.ri.gov/voting/registration.php>.

**You may ask for an appeal** if you disagree with an eligibility determination made during your use of HealthSource RI that affects your eligibility for a health plan through HealthSource RI. Pursuant to proposed new EOHHS Rule “Complaints and Hearings #0110,” you may file an appeal of this determination and the matter will be heard by a hearing officer. You must file the appeal within 30 days of receiving the notice of action you wish to appeal. You may also have the opportunity to resolve the matter through an information resolution process. You can find more information about the HealthSource RI appeals process by visiting the HealthSource RI at [www.healthsourceri.com](http://www.healthsourceri.com) or by calling the HealthSource RI Contact Center at 1-855-609-3304.

**Health Insurance Portability and Accountability Act (HIPAA)** restrictions prevent us from discussing the health information of you or any member of your household with anyone, including an authorized representative, unless that individual has power of attorney or you have signed a consent form allowing the disclosure of this information. This includes disclosure of mental health information, HIV, AIDS, STD test results, or treatment and chemical dependency services.

**The information that you give HealthSource RI** is subject to verification by federal and state officials. In order to review your Application and to determine whether you qualify to purchase a plan, HealthSource RI must obtain confidential financial and other information from state and federal agencies. This process may also include follow-up contacts from agency staff.

**HealthSource RI is not responsible for administering your health insurance plan.** Your health insurance carrier can provide you more information about your benefits. **If you have questions about the terms of your health insurance plan, including what benefits you are eligible for, out of pocket expenses under your plan, and making a benefit claim or appealing a denial of benefits, you should contact your health insurance carrier.** If you are eligible for COBRA following the termination of any health insurance coverage, administering COBRA and providing you the required COBRA notices and election periods is your former employer's or issuer's responsibility.

Do not cancel any current insurance coverage or decline any COBRA benefits until you receive an approval letter and insurance policy, also known as insurance contract or certificate, from the insurance carrier you selected. Make sure you understand and agree with the terms of the policy, pay special attention to the effective date, waiting periods, premium amount, benefits, limitations, exclusions, and riders.

## **Things you should know for qualified health plans:**

**If you enroll in a qualified health plan through HealthSource RI and you do not provide enough information for HealthSource RI to verify your eligibility** to purchase a plan, or if any information you provide is not verifiable, you will have 90 days to provide further information to satisfy HealthSource RI's eligibility requirements. During this time, you should work with HealthSource RI staff to try to provide any missing information or resolve any inconsistencies so that your coverage and applicable costs may be effective as soon as possible.

**Premium rates are subject to change** based on the health insurance carrier's underwriting practices

and your selection of available optional benefits, if any. Final rates are always determined by the health insurance carrier.

**Premium rates are for your requested effective date ONLY.** If the actual effective date of your policy is different from your requested effective date, the actual cost of your policy may differ from the rates listed on HealthSourceRI.com, due to rate increases or policy changes from the insurance company and/or one or more family members having a birthday. (Rates are highly dependent on age.) The carrier you selected may not guarantee their rates for any period of time until a contract is signed.

# Application for Health Care Coverage

## About You and Your Family

Please include the following individuals on this application: yourself; your spouse; your unmarried partner who lives with you, but only if you have children together who need health insurance; your children; and anyone you include on your federal tax return, even if they don't live with you. Anyone else who lives with you will need to file their own application. You can complete an application for other people in your family even if you don't need coverage for yourself, or are not eligible for coverage. You can skip the questions on SSNs for family members who are not applying for coverage.

### Primary Applicant - We need one adult in the family to be the contact for the application

1. First Name		Middle Name		Last Name		Suffix (e.g. Jr., I, II etc.)	
2. Gender <input type="checkbox"/> M <input type="checkbox"/> F				3. Date of Birth Month: _____ Day: _____ Year: _____			
4. Are you applying for Medical coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No				5. Are you applying for Dental coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No			
6. Do you have a Social Security number? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If you have an SSN, enter it here.</b>				7. My Name is different on my Social Security card: <input type="checkbox"/> Yes <input type="checkbox"/> No			
6a. Social Security number (SSN): _____				7a. <b>If YES</b> , Name on Card: _____			

### Family Member 2 – You can skip questions 13-14 if this person is not applying for health coverage

8. First Name		Middle Name		Last Name		Suffix (e.g. Jr., I, II etc.)	
9. Gender <input type="checkbox"/> M <input type="checkbox"/> F				10. Date of Birth Month: _____ Day: _____ Year: _____			
11. Is this person applying for Medical coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No				12. Is this person applying for Dental coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No			
13. Does this person have a Social Security number? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If this person has an SSN, enter it here.</b>				14. Is this person's name is different on his or her Social Security card: <input type="checkbox"/> Yes <input type="checkbox"/> No			
13a. Social Security number (SSN): _____				14a. <b>If YES</b> , Name on Card: _____			

### Family Member 3 – You can skip questions 20-21 if this person is not applying for health coverage

15. First Name		Middle Name		Last Name		Suffix (e.g. Jr., I, II etc.)	
16. Gender <input type="checkbox"/> M <input type="checkbox"/> F				17. Date of Birth Month: _____ Day: _____ Year: _____			
18. Is this person applying for Medical coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No				19. Is this person applying for Dental coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No			
20. Does this person have a Social Security number? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If this person has an SSN, enter it here.</b>				21. Is this person's name is different on his or her Social Security card: <input type="checkbox"/> Yes <input type="checkbox"/> No			
20a. Social Security number (SSN): _____				21a. <b>If YES</b> , Name on Card: _____			

### Family Member 4 – You can skip questions 27-28 if this person is not applying for health coverage

22. First Name		Middle Name		Last Name		Suffix (e.g. Jr., I, II etc.)	
23. Gender <input type="checkbox"/> M <input type="checkbox"/> F				24. Date of Birth Month: _____ Day: _____ Year: _____			
25. Is this person applying for Medical coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No				26. Is this person applying for Dental coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No			
27. Does this person have a Social Security number? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If this person has an SSN, enter it here.</b>				28. Is this person's name different on his or her Social Security card: <input type="checkbox"/> Yes <input type="checkbox"/> No			
27a. Social Security number (SSN): _____				28a. <b>If YES</b> , Name on Card: _____			

*Photocopy this sheet to add additional family members.*

## Tell Us About Yourself – Primary Applicant

**1.** First Name \_\_\_\_\_ Middle Name \_\_\_\_\_ Last Name \_\_\_\_\_ Suffix (e.g. Jr., I, II etc.) \_\_\_\_\_

<b>2.</b> Primary Phone Number <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work (   )   (   )	<b>3.</b> Secondary Phone Number <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work (   )   (   )	<b>4.</b> Email Address
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**5.** HealthSource RI may need to contact you regarding the status of your application and/or request additional information. What is your preferred method of contact?    Email    Paper Mail

**6.** What is your preferred time of contact for calls?    Morning    Afternoon    Evening    Weekend    Anytime

**7.** Preferred spoken language (lengua hablada preferida)  
 English    Español    Português

**8.** Preferred written language (lenguaje escrito preferido)  
 English    Español    Português

<b>9.</b> Home Address	Apt/Unit #	City	State	Zip Code
<b>10.</b> Mailing Address ( <i>if different</i> )	Apt/Unit #	City	State	Zip Code

### Your Additional Information

**11.** Ethnicity (Optional)    Hispanic/Latino    Non Hispanic/Latino

**12.** Race (Optional)  
 White    Black or African American    Asian    American Indian or Alaskan Native  
 Pacific Islander/Native Hawaiian    Indian    Other

**13.** Are you currently incarcerated?    Yes    No

**13a. If YES:** Expected Release Date: Month: \_\_\_\_\_ Day: \_\_\_\_\_ Year: \_\_\_\_\_

## Your Citizenship and Immigration Information

*You don't need to answer questions 11-14 if you're not applying for coverage.*

**14.** Immigration Status: (check one)  U.S. Citizen/National  Naturalized Citizen†  Eligible Immigrant†  Other

**15.** If a non-citizen, have you lived in the U.S. for any length of time prior to 08/22/1996?  Yes  No

**16. †If you are NOT a U.S. Citizen or National or if you are a Naturalized Citizen, please provide information on your documentation.**

Document Type	Document Number	Expiration(MM/DD/YY)
<b>16a.</b> Certificate of Citizenship: Alien #:	<input type="checkbox"/> Citizenship Number	Not applicable
<b>16b.</b> Naturalization Certificate: Alien #:	<input type="checkbox"/> Naturalization Number	Not applicable
<b>16c.</b> Reentry Permit (I-327): Alien #:	<input type="checkbox"/>	
<b>16d.</b> Permanent Resident Card ("Green Card," I-551): Alien #:	<input type="checkbox"/> I-551 Number:	
<b>16e.</b> Refugee Travel Document (I-571) Alien #:	<input type="checkbox"/>	
<b>16f.</b> Employment Authorization Card (I-766) Alien #:	<input type="checkbox"/>	
<b>16g.</b> Machine Readable Immigrant Visa (with temporary I-551 language). Visa Number: _____ Country of Issuance: _____ Alien Number: _____	<input type="checkbox"/> Passport Number:	
<b>16h.</b> Temporary I-551 Stamp (on passport or I-94, I-94A) Country of Issuance: _____ Alien Number: _____	<input type="checkbox"/> Passport Number:	
<b>16i.</b> Arrival/Departure Record (I-94, I-94A) issued by U.S. Citizenship and Immigration Services Sevis ID: _____	<input type="checkbox"/> I-94 Number:	
<b>16j.</b> Arrival/Departure Record in unexpired foreign passport (I-94) Country of Issuance: _____ Sevis ID: _____ Visa Number: _____	<input type="checkbox"/> Passport Number:  I-94 Number:	
<b>16k.</b> Unexpired foreign passport Country of Issuance: _____ Sevis ID: _____	<input type="checkbox"/> Passport Number:  I-94 Number:	
<b>16l.</b> Certificate of Eligibility for Nonimmigrant (F-1) Student Status (I-20) Sevis ID: _____	<input type="checkbox"/> Passport Number:  I-94 Number:	
<b>16m.</b> Certificate of Eligibility for Exchange Visitor (J-1) Status (DS2019) Sevis ID: _____	<input type="checkbox"/> Passport Number:  I-94 Number:	
<b>16n.</b> Other documents or status types Document Description: _____ Alien Number: _____ Sevis ID: _____	<input type="checkbox"/> Passport Number:  I-94 Number:	

**17. If your name is different on your immigration document, please provide the name on the document:**

First Name                      Middle Name                      Last Name                      Suffix (e.g. Jr., I, II etc.)

### **Veteran's Information about You**

**18.** Are you, your spouse or parent a veteran or an active duty member in the U.S. military?  Yes  No

### **American Indian & Alaskan Native Information for You**

American Indian and Alaskan Natives may be eligible for special benefits through the Health Benefit Exchange.

**19.** Are you an American Indian or Alaskan Native?  Yes  No **If NO**, skip to Family Member 2 questions, if applicable.

**If YES:**

**19a.** Are you a member of a Federally Recognized Tribe?  Yes  No

**19b.** Tribe Name \_\_\_\_\_ State \_\_\_\_\_

**19c.** Have you ever gotten services from an Indian health service, tribal program or urban Indian health program?  
 Yes  No

**19d.** Are you eligible to receive services from an Indian health service, tribal health program or urban Indian health program through a referral from one of these programs?  Yes  No

**Family Member 2 - Skip to page 18 if there is no one else in your family**

1. First Name	M.I.	Last Name	Suffix (e.g. Jr., I, II etc.)		
2. Does this person live with You, the Primary Applicant? <input type="checkbox"/> Yes <input type="checkbox"/> No					
3. If NO, this person's Home Address		Apt/Unit #	City	State	Zip Code
4. Is this person living outside of Rhode Island temporarily? <input type="checkbox"/> Yes <input type="checkbox"/> No					
<b>5. Relationship to You, the Primary Applicant:</b>					
<input type="checkbox"/> Brother/sister	<input type="checkbox"/> Spouse	<input type="checkbox"/> Son/daughter	<input type="checkbox"/> Parent		
<input type="checkbox"/> Uncle/aunt	<input type="checkbox"/> Domestic Partner	<input type="checkbox"/> Stepson/stepdaughter	<input type="checkbox"/> Stepparent		
<input type="checkbox"/> First cousin	<input type="checkbox"/> Former spouse	<input type="checkbox"/> Nephew/niece	<input type="checkbox"/> Guardian		
<input type="checkbox"/> Son-in-law/daughter-in-law		<input type="checkbox"/> Child of domestic partner	<input type="checkbox"/> Father-in-law/ mother-in-law		
<input type="checkbox"/> Brother-in-law/sister-in-law		<input type="checkbox"/> Grandchild	<input type="checkbox"/> Grandparent		
<input type="checkbox"/> Trustee		<input type="checkbox"/> Adopted son/daughter	<input type="checkbox"/> Parent's domestic partner		
<input type="checkbox"/> Ward		<input type="checkbox"/> Foster child			
<input type="checkbox"/> Non-relative caretaker		<input type="checkbox"/> Sponsored dependent			
6. Ethnicity (Optional) <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non Hispanic/Latino					
7. Race (Optional)					
<input type="checkbox"/> White	<input type="checkbox"/> Black or African American	<input type="checkbox"/> Asian	<input type="checkbox"/> American Indian or Alaskan Native		
<input type="checkbox"/> Pacific Islander/Native Hawaiian		<input type="checkbox"/> Indian	<input type="checkbox"/> Other		
8. Is this person currently incarcerated? <input type="checkbox"/> Yes <input type="checkbox"/> No					
8a. If YES: Expected Release Date: Month: _____ Day: _____ Year: _____					

## Family Member 2 - Citizenship and Immigration Information

You don't need to answer questions 9-12 if this person is not applying for coverage.

**9. Immigration Status:** (check one)  U.S. Citizen/National  Naturalized Citizen†  Eligible Immigrant†  Other

**10.** If a non-citizen, has this person lived in the U.S. for any length of time prior to 08/22/1996?  Yes  No

**11. †If this person is NOT a U.S. Citizen or National or if s/he is a Naturalized Citizen, please provide information on documentation.**

Document Type	Document Number	Expiration(MM/DD/YY)
<b>11a.</b> Certificate of Citizenship: Alien #:	<input type="checkbox"/> Citizenship Number	Not applicable
<b>11b.</b> Naturalization Certificate: Alien #:	<input type="checkbox"/> Naturalization Number	Not applicable
<b>11c.</b> Reentry Permit (I-327): Alien #:	<input type="checkbox"/>	
<b>11d.</b> Permanent Resident Card ("Green Card," I-551): Alien #:	<input type="checkbox"/> I-551 Number:	
<b>11e.</b> Refugee Travel Document (I-571) Alien #:	<input type="checkbox"/>	
<b>11f.</b> Employment Authorization Card (I-766) Alien #:	<input type="checkbox"/>	
<b>11g.</b> Machine Readable Immigrant Visa (with temporary I-551 language). Visa Number: _____ Country of Issuance: _____ Alien Number: _____	<input type="checkbox"/> Passport Number:	
<b>11h.</b> Temporary I-551 Stamp (on passport or I-94, I-94A) Country of Issuance: _____ Alien Number: _____	<input type="checkbox"/> Passport Number:	
<b>11i.</b> Arrival/Departure Record (I-94, I-94A) issued by U.S. Citizenship and Immigration Services Sevis ID: _____	<input type="checkbox"/> I-94 Number:	
<b>11j.</b> Arrival/Departure Record in unexpired foreign passport (I-94) Country of Issuance: _____ Sevis ID: _____ Visa Number: _____	<input type="checkbox"/> Passport Number:  I-94 Number:	
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**12.** If this person's name is different on his or her immigration document, please provide the name on the document:

First Name	Middle Name	Last Name	Suffix (e.g. Jr., I, II etc.)
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**Family Member 2 - Veteran's Information**

**13.** Is this person, his or her spouse or parent a veteran or an active duty member in the U.S. military?  Yes  No

**Family Member 2 - American Indian & Alaskan Native Information**

American Indian and Alaskan Natives may be eligible and for special benefits through the Health Benefit Exchange.

**14.** Is this person an American Indian or Alaskan Native?  Yes  No **(If NO, skip to Family Member 3 questions, if applicable.)**

**If YES:**

**14a.** Is this person a member of a Federally Recognized Tribe?  Yes  No

**14b.** Tribe Name \_\_\_\_\_ **14c.** State \_\_\_\_\_

**14d.** Has this person ever gotten services from an Indian health service, tribal program or urban Indian health program?  Yes  No

**14e.** Is this person eligible to receive services from an Indian health service, tribal health program or urban Indian health program through a referral from one of these programs?  Yes  No

**Family Member 3 - Skip to page 18 if there is no one else in your family**

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<input type="checkbox"/> Brother-in-law/sister-in-law		<input type="checkbox"/> Grandchild	<input type="checkbox"/> Grandparent		
<input type="checkbox"/> Trustee		<input type="checkbox"/> Adopted son/daughter	<input type="checkbox"/> Parent's domestic partner		
<input type="checkbox"/> Ward		<input type="checkbox"/> Foster child			
<input type="checkbox"/> Non-relative caretaker		<input type="checkbox"/> Sponsored dependent			
6. Ethnicity (Optional) <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non Hispanic/Latino					
7. Race (Optional)					
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<input type="checkbox"/> Pacific Islander/Native Hawaiian		<input type="checkbox"/> Indian	<input type="checkbox"/> Other		
8. Is this person currently incarcerated? <input type="checkbox"/> Yes <input type="checkbox"/> No					
8a. If YES: Expected Release Date: Month: _____ Day: _____ Year: _____					

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<b>11e.</b> Refugee Travel Document (I-571) Alien #:	<input type="checkbox"/>	
<b>11f.</b> Employment Authorization Card (I-766) Alien #:	<input type="checkbox"/>	
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<b>11i.</b> Arrival/Departure Record (I-94, I-94A) issued by U.S. Citizenship and Immigration Services Sevis ID: _____	<input type="checkbox"/> I-94 Number:	
<b>11j.</b> Arrival/Departure Record in unexpired foreign passport (I-94) Country of Issuance: _____ Sevis ID: _____ Visa Number: _____	<input type="checkbox"/> Passport Number:  I-94 Number:	
<b>11k.</b> Unexpired foreign passport Country of Issuance: _____ Sevis ID: _____	<input type="checkbox"/> Passport Number:  I-94 Number:	
<b>11L.</b> Certificate of Eligibility for Nonimmigrant (F-1) Student Status (I-20) Sevis ID: _____	<input type="checkbox"/> Passport Number:  I-94 Number:	
<b>11m.</b> Certificate of Eligibility for Exchange Visitor (J-1) Status (DS2019) Sevis ID: _____	<input type="checkbox"/> Passport Number:  I-94 Number:	
<b>11n.</b> Other documents or status types Document Description: _____ Alien Number: _____ Sevis ID: _____	<input type="checkbox"/> Passport Number:  I-94 Number:	

**12.** If this person's name is different on his or her immigration document, please provide the name on the document:

First Name	Middle Name	Last Name	Suffix (e.g. Jr., I, II etc.)
------------	-------------	-----------	-------------------------------

**Family Member 3 - Veteran's Information**

**13.** Is this person, his or her spouse or parent a veteran or an active duty member in the U.S. military?  Yes  No

**Family Member 3 - American Indian & Alaskan Native Information**

American Indian and Alaskan Natives may be eligible and for special benefits through the Health Benefit Exchange.

**14.** Is this person an American Indian or Alaskan Native?  Yes  No **(If NO, skip to Family Member 4 questions, if applicable.)**

**If YES:**

**14a.** Is this person a member of a Federally Recognized Tribe?  Yes  No

**14b.** Tribe Name \_\_\_\_\_ **14c.** State \_\_\_\_\_

**14d.** Has this person ever gotten services from an Indian health service, tribal program or urban Indian health program?  Yes  No

**14e.** Is this person eligible to receive services from an Indian health service, tribal health program or urban Indian health program through a referral from one of these programs?  Yes  No

**Family Member 4 - Skip to page 18 if there is no one else in your family**

1. First Name		M.I.	Last Name		Suffix (e.g. Jr., I, II etc.)	
2. Does this person live with You, the Primary Applicant? <input type="checkbox"/> Yes <input type="checkbox"/> No						
3. If NO, this person's Home Address			Apt/Unit #	City	State	Zip Code
4. Is this person living outside of Rhode Island temporarily? <input type="checkbox"/> Yes <input type="checkbox"/> No						
<b>5. Relationship to You, the Primary Applicant:</b>						
<input type="checkbox"/> Brother/sister	<input type="checkbox"/> Spouse	<input type="checkbox"/> Son/daughter	<input type="checkbox"/> Parent			
<input type="checkbox"/> Uncle/aunt	<input type="checkbox"/> Domestic Partner	<input type="checkbox"/> Stepson/stepdaughter	<input type="checkbox"/> Stepparent			
<input type="checkbox"/> First cousin	<input type="checkbox"/> Former spouse	<input type="checkbox"/> Nephew/niece	<input type="checkbox"/> Guardian			
<input type="checkbox"/> Son-in-law/daughter-in-law		<input type="checkbox"/> Child of domestic partner	<input type="checkbox"/> Father-in-law/ mother-in-law			
<input type="checkbox"/> Brother-in-law/sister-in-law		<input type="checkbox"/> Grandchild	<input type="checkbox"/> Grandparent			
<input type="checkbox"/> Trustee		<input type="checkbox"/> Adopted son/daughter	<input type="checkbox"/> Parent's domestic partner			
<input type="checkbox"/> Ward		<input type="checkbox"/> Foster child				
<input type="checkbox"/> Non-relative caretaker		<input type="checkbox"/> Sponsored dependent				
6. Ethnicity (Optional) <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non Hispanic/Latino						
7. Race (Optional)						
<input type="checkbox"/> White	<input type="checkbox"/> Black or African American	<input type="checkbox"/> Asian	<input type="checkbox"/> American Indian or Alaskan Native			
<input type="checkbox"/> Pacific Islander/Native Hawaiian		<input type="checkbox"/> Indian	<input type="checkbox"/> Other			
8. Is this person currently incarcerated? <input type="checkbox"/> Yes <input type="checkbox"/> No						
8a. If YES: Expected Release Date: Month: _____ Day: _____ Year: _____						

## Family Member 4 - Citizenship and Immigration Information

*You don't need to answer questions 9-12 if this person is not applying for coverage.*

**9. Immigration Status:** (check one)  U.S. Citizen/National  Naturalized Citizen†  Eligible Immigrant†  Other

**10.** If a non-citizen, has this person lived in the U.S. for any length of time prior to 08/22/1996?  Yes  No

**11. †If this person is NOT a U.S. Citizen or National or if s/he is a Naturalized Citizen, please provide information on documentation.**

Document Type	Document Number	Expiration(MM/DD/YY)
<b>11a.</b> Certificate of Citizenship: Alien #:	<input type="checkbox"/> Citizenship Number	Not applicable
<b>11b.</b> Naturalization Certificate: Alien #:	<input type="checkbox"/> Naturalization Number	Not applicable
<b>11c.</b> Reentry Permit (I-327): Alien #:	<input type="checkbox"/>	
<b>11d.</b> Permanent Resident Card ("Green Card," I-551): Alien #:	<input type="checkbox"/> I-551 Number:	
<b>11e.</b> Refugee Travel Document (I-571) Alien #:	<input type="checkbox"/>	
<b>11f.</b> Employment Authorization Card (I-766) Alien #:	<input type="checkbox"/>	
<b>11g.</b> Machine Readable Immigrant Visa (with temporary I-551 language). Visa Number: _____ Country of Issuance: _____ Alien Number: _____	<input type="checkbox"/> Passport Number:	
<b>11h.</b> Temporary I-551 Stamp (on passport or I-94, I-94A) Country of Issuance: _____ Alien Number: _____	<input type="checkbox"/> Passport Number:	
<b>11i.</b> Arrival/Departure Record (I-94, I-94A) issued by U.S. Citizenship and Immigration Services Sevis ID: _____	<input type="checkbox"/> I-94 Number:	
<b>11j.</b> Arrival/Departure Record in unexpired foreign passport (I-94) Country of Issuance: _____ Sevis ID: _____ Visa Number: _____	<input type="checkbox"/> Passport Number:  I-94 Number:	
<b>11k.</b> Unexpired foreign passport Country of Issuance: _____ Sevis ID: _____	<input type="checkbox"/> Passport Number:  I-94 Number:	
<b>11L.</b> Certificate of Eligibility for Nonimmigrant (F-1) Student Status (I-20) Sevis ID: _____	<input type="checkbox"/> Passport Number:  I-94 Number:	
<b>11m.</b> Certificate of Eligibility for Exchange Visitor (J-1) Status (DS2019) Sevis ID: _____	<input type="checkbox"/> Passport Number:  I-94 Number:	
<b>11n.</b> Other documents or status types Document Description: _____ Alien Number: _____ Sevis ID: _____	<input type="checkbox"/> Passport Number:  I-94 Number:	

**12.** If this person's name is different on his or her immigration document, please provide the name on the document:

First Name	Middle Name	Last Name	Suffix (e.g. Jr., I, II etc.)
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**Family Member 4 - Veteran's Information**

**13.** Is this person, his or her spouse or parent a veteran or an active duty member in the U.S. military?  Yes  No

**Family Member 4 - American Indian & Alaskan Native Information**

American Indian and Alaskan Natives may be eligible and for special benefits through the Health Benefit Exchange.

**14.** Is this person an American Indian or Alaskan Native?  Yes  No **(If NO, skip to Authorized Representative questions, if applicable.)**

**If YES:**

**14a.** Is this person a member of a Federally Recognized Tribe?  Yes  No

**14b.** Tribe Name \_\_\_\_\_ **14c.** State \_\_\_\_\_

**14d.** Has this person ever gotten services from an Indian health service, tribal program or urban Indian health program?  Yes  No

**14e.** Is this person eligible to receive services from an Indian health service, tribal health program or urban Indian health program through a referral from one of these programs?  Yes  No

## Authorized Representative Information

An Authorized Representative is someone who is helping you get health insurance. This can be a relative or a friend. You have given them permission to see your personal information and to make decisions about your health insurance coverage. By designating an authorized representative, you are giving permission for your authorized representative to:

- Sign the application on your behalf;
- Receive notices related to your application and account; and
- Act on your behalf for all matters related to the application and account.

If you ever need to change your authorized representative, contact HealthSource RI.

**Do you have an authorized representative?**  Yes  No

If **YES**, please answer the following questions.

**1.** Authorized Representative's First Name, Middle Name, Last Name & Suffix (e.g. Jr., I, II etc.)

**1a.** Primary Phone Number

Cell  Home  Work  
( )

**1b.** Secondary Phone Number

Cell  Home  Work  
( )

**1c.** Email Address

**1d.** HealthSource RI may need to contact you regarding the status of the application and/or request additional information. Authorized Representative's preferred method of contact  Email  Paper Mail

**1e.** What is the preferred time of contact (for phone calls)?  Morning  Afternoon  Evening  Weekend  Anytime

**1f.** Preferred spoken language (lengua hablada preferida)

English  Español  Português

**1g.** Preferred written language (lenguaje escrito preferido)

English  Español  Português

**1h.** Mailing Address

Apt/Unit #

City

State

Zip Code

**1i.** Company Name (If Applicable)

**1j.** Organization ID (If Applicable)

**1k.** The **primary applicant** must sign below to acknowledge that they have an authorized representative who can make decisions on their behalf.

**Signature X** \_\_\_\_\_

## For Certified Application Counselors, Navigators, Agents, and Brokers Only

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

**2.** Application start date (MM/DD/YYYY)

**2a.** First name

Middle Name

Last Name

Suffix (e.g. Jr., I, II etc.)

**2b.** Organization name

**2c.** ID number (if applicable)

## Read Carefully Before Signing

### YOUR CONSENT FOR ACCESS TO AND SHARING OF ELECTRONIC DATA

You have applied for participation in the Rhode Island Health Benefits Exchange (“Exchange”). You understand that you are not, as part of this application, applying for any financial support for the purchase of coverage nor seeking to determine your eligibility for publicly-funded coverage or other programs and supports.

If you would like to know whether you are eligible for any financial support for the purchase of coverage or whether you are eligible for publicly-funded coverage or other programs and supports, it will be necessary for you to fill out a different application than the one you are currently using.

I understand that I am not applying for financial support and wish to proceed to submit an application for and purchase health insurance without checking my eligibility for other programs and supports.

I understand that I may change my consent at any time through HealthSource RI.

Yes  No

I have read or had explained to me my rights and responsibilities and received a copy of the HealthSource RI Rights and Responsibilities (listed on pages 3-4 of this application).

Yes  No

## Declaration and Signature

I have read and understood the information in this application. I certify under penalty of perjury that my answers are correct, including information about citizenship and alien status, and complete to the best of my knowledge and belief.

I know that under the state of Rhode Island General Laws, Section 40-6-15, a maximum fine of \$1,000, or imprisonment of up to five (5) years, or both, may be imposed for a person who obtains or attempts to obtain, or aids or abets any person to obtain, public assistance to which s/he is not entitled or who willfully fails to report income, resources, or personal circumstances or increases therein which exceed the amount previously reported.

Under penalty of perjury, I attest to the identity of the minor children identified herein and that all of the information contained in this application is true. I understand that I am breaking the law if I give wrong information and can be punished under federal law, state law or both.

Signature \_\_\_\_\_

Date \_\_\_\_\_

Spouse's Signature \_\_\_\_\_

Date \_\_\_\_\_



## APPENDIX A

# STATE of RHODE ISLAND

HealthSource RI and RI Executive Office of Health & Human Services

### Notice of Privacy Practices

This notice describes how personal and medical information about individuals may be collected, used and disclosed by HealthSourceRI and how individuals may get access to this information.

HealthSource RI is strongly committed to protecting the privacy of its users. Personally identifiable information will only be used to help users find, apply for, buy, and enroll into health coverage, including both public and private options. We use industry-leading technologies to ensure the security and confidentiality of the personally identifiable information provided to us by our users.

If at any time an individual has questions about their consent to share personally identifiable information or would like to revoke consent for HealthSource RI to use their personally identifiable information for the purposes described in this notice, they must contact HealthSourceRI at 1-855-609-3304.

Throughout this policy, we refer to information that can identify you as a specific individual, such as your name, phone number, email address, Social Security number or credit card number, as “personally identifiable information.” “Personally identifiable information” also includes any information involving your health or medical history.

Please note the following important information regarding our privacy policy:

**1. The use and disclosure of information concerning applicants and enrollees will be limited to purposes directly connected with the following:**

- a. The administration of HealthSource RI. Such purposes include determining eligibility for enrollment in health coverage, determining eligibility for other insurance affordability programs or determining eligibility for exemptions from the requirement to have health coverage.
- b. Any investigation, prosecution, or criminal or civil proceeding conducted in connection with the administration of HealthSource RI.
- c. The administration of any other federal or state assisted program which provides assistance, in cash or in kind, or services, directly to individuals on the basis of need.
- d. Any other release will be made with the applicant/enrollee’s consent.

**2. The following information describes the collection of personally identifiable information in the normal course of business of HealthSource RI in order to process insurance applications.**

**a. Registration**

We begin collecting personally identifiable information from individuals when they register with us. Individuals may register with us through our website ([healthsourceri.com](http://healthsourceri.com)) by entering an email address and, if they are creating an account, choosing a password. Individuals may

also register with us through our Contact Center by providing certain personal or contact information (e.g., email address, phone number, gender, date of birth) to one of our customer service representatives.

**b. Applying for Health Insurance and Other Products.**

If an individual applies for a health insurance or other product through our website, we may ask them to provide us with personally identifiable information and/or health information relating to him or her and any family member who will be included on his or her application. This information will be used by the individual's chosen insurance company to process their application. Additionally, we may ask for credit card or bank information, which will be used to process applications or collect any fees associated with applications or insurance premiums upon approval of an application.

**c. Providing a quote or processing applications.**

We may use personally identifiable information to get in touch with applicants/enrollees when necessary to process an application or to provide a quote. For example, emails will be sent throughout the application process to inform applicants/enrollees of the status of the application and to seek additional information that is requested as part of the application.

**d. Customer satisfaction, referrals and other products.**

We or our service providers may contact applicants/enrollees to survey their satisfaction of our service, refer our products and services to other people, and/or to inform them of additional products and services.

**3. We do not sell personally identifiable information to anyone.**

**4. We do not disclose personally identifiable information to third parties, unless one of the following limited exceptions applies.**

**I. Insurance Companies, Licensed Agents/Brokers and Navigators, state and federal government.** When someone submits an application for an insurance product offered by us, then we will disclose his or her personally identifiable information to his or her chosen insurance company to process his or her application.

**II. If someone submits an application for an insurance product offered through an insurance agent or agency, or through a Navigator or other application assister who has a relationship with us, then we may share his or her personally identifiable information with that party for the purposes of processing his or her application or enrollment.** These partners are only allowed to use personally identifiable information to process the requested quote, application or enrollment form and that they are contractually obligated to maintain confidentiality.

**III. Service Providers.** We may disclose personally identifiable information to other companies that help us process or service insurance applications or correspond with applicants/enrollees.

For example, we may provide personally identifiable information to a service provider to send enrollees monthly bills and process payments received. The companies we hire to process or service insurance applications or correspond with applicants/enrollees are not allowed to use personally identifiable information for their own purposes and are contractually obligated to maintain confidentiality.

**IV. Legal Obligations.** We may disclose or report personally identifiable information when we believe, in good faith, that the disclosure is required or permitted under law, for example, to cooperate with regulators or law enforcement authorities or to resolve consumer disputes.

**V. Consent.** We may disclose or report personally identifiable information to third parties only upon written consent from the individual whose personally identifiable information we intend to disclose. For example, we may disclose personally identifiable information to a friend or relative helping an individual to obtain health coverage, but only with that individual's consent to do so.

Outside of the above exceptions, we will not share personally identifiable information with third parties.

**5. We gather anonymous information about users for our internal purposes, and we may share this anonymous information with third parties.**

Anonymous information is any information that does not personally identify an individual, including aggregate demographic information such as the number of visitors to our website from a particular state. We use anonymous information primarily for marketing purposes and to improve the services we offer.

We may use “Cookies,” “Clear Gifs,” “Internet Protocol” addresses and other monitoring technologies to gather anonymous information. “Cookies” are small files that are stored by your web browser to help a particular system recognize a user and the pages they have visited in a website. “Clear gifs” are tiny graphics with a unique identifier, similar in function to cookies, that are used to track the online movements of website users. More information on each of these tools is below.

**“Cookies:”** Our website uses cookies to make a user's online experience more convenient. For example, we may use a cookie to store account information between sessions and to maintain information about the quotes a user requested during his or her session. Additionally, we may use data from cookies for a variety of internal purposes, such as studying how users navigate our website. We do not collect any personally identifiable information from cookies. Further, no other information we collect from cookies can be linked back to personally identifiable information. Most browsers automatically accept cookies, but if you prefer, you can set yours to refuse cookies. Even without a cookie, you can still use most of the features on our website, including obtaining quotes and applying for an insurance policy.

**“Clear gifs:”** The main difference between a “cookie” and a “clear gif” is that clear gifs are invisible on the page and are much smaller than cookies. We do not collect any personally identifiable

information from clear gifs. Further, no information we collect from clear gifs can be linked back to your personally identifiable information.

We use third party web analytics services to track and analyze anonymous usage and volume statistical information from visitors to help us administer our website, analyze trends, improve our website's performance and to report website traffic. These web analytics services use cookies, clear gifs, log files and other web monitoring technologies to help track visitor behavior on our behalf. These services do not use these technologies to collect any personally identifiable information from website visitors.

**6. We protect the confidentiality and security of personally identifiable information.**

We maintain physical, electronic and procedural safeguards to protect your personally identifiable information.

**7. We continue to evaluate our efforts to protect personally identifiable information and make every effort to keep personally identifiable information accurate and up to date.**

We will conduct a yearly review of any and all privacy risks, including any major updates or changes to our system and/or privacy policy. Any and all risks and changes will be reviewed and addressed as appropriate by our information security and privacy officers. Our information security and privacy officers will also be responsible for the proactive review of the processes by which your personal information is collected and maintained (including when your personally identifiable information is collected or shared with the third parties listed in #4), used, disclosed, retained and disposed of.

If an individual's personally identifiable information changes or if they wish to dispute the accuracy or integrity of their personally identifiable information or if an individual would like to correct or update their information, they may contact us at 1-855-609-3304.

Individuals may also update their contact information using the contacts provided above.

Additionally, names, email addresses and passwords may be updated by clicking on the "Sign in" link on the HealthSource RI website (healthsourceri.com) and signing in using the user's email address and password.

We will retain your information for as long as your account is active or as needed to provide you services. We will retain and use your information as necessary to comply with our legal obligations, resolve disputes, and enforce our agreements.

Once an application has been submitted to a health insurance company, individuals may have to contact the insurance company directly to update their application.

**8. We will provide a notice of changes in our information privacy practices.**

If we are going to use personally identifiable information in a manner different from that stated at the time of collection, we will notify all users via email or if previously requested, by another contact method. Users will have a choice as to whether or not we use their personally identifiable information in this new or different manner. If we make any material changes to our privacy practices that do not affect the personally identifiable information already stored in our

database, we will post a prominent notice in the privacy portion of our website notifying users of the change.

If our system undergoes any major changes we will post a prominent notice in the privacy portion of our website notifying users of the change.

This notice and any future changes to it will be available on our website.

**9. Individuals may opt out of receiving satisfaction surveys and/or information on additional products and services from us.**

We may contact users to survey their satisfaction with our service and/or to inform them of additional products and services.

Users may opt out of these surveys and/or notices by contacting us 1-855-609-3304.

Users will still receive communications from us regarding insurance quotes, applications or policies even if they opt out of receiving our surveys and/or notices of additional products and services.

**10. We are available to answer any questions that may arise about our privacy policy or our information privacy practices.**

Questions can be sent to us by calling our Contact Center at 1-855-609-3304. We will respond to such questions within 30 days.

**11. Links to Other Websites**

Our website contains links to other websites. Please note that when you click on one of these links you are “clicking” to another website. We are not responsible for the information privacy practices or the content of such websites. We encourage you to read the privacy policies of these linked websites as their information privacy practices may differ from ours.



## Notice to Applicant Registering to Vote in Rhode Island

The State Board of elections urges all of its citizens to register to vote. Your vote will benefit you and your family.

Included in this packet of forms is a voter registration form. If you would to register to vote, complete and sign the form and mail it to your local Board of Canvassers. (directory listed on the back of the form)

### Register to vote

- If you are not registered to vote where you live today, complete the enclosed form.
- Applying to register or declining to register to vote will not affect the amount of assistance provided by this agency.
- If you would like help in completing the voter registration application form, you can bring it with you when you return the other completed forms in this package, or go to the local Board of Canvassers in the city/town where you live. (City/Town directory is on the back of the voter registration form.) The decision whether to seek or accept help is yours.
- If you believe that someone has interfered with your right to register or decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the Voter Registration Coordinator, 50 Branch Avenue, Providence, RI 02904 or (401)222-2345.



# RHODE ISLAND VOTER REGISTRATION FORM

Please print clearly in ink. All information is required unless marked optional.

## YOU MAY USE THIS FORM TO:

- Register to vote in Rhode Island.
- Change your name and/or address on your registration.
- Choose a political party or change parties.

## TO REGISTER TO VOTE IN RI YOU MUST BE:

- A legal resident of Rhode Island.
- A citizen of the United States.
- At least 16 years of age.  
(You must be at least 18 years of age to vote on Election Day.)

### INSTRUCTIONS

**Box 2: REQUIRED.** Rhode Island citizens who are at least 16 years of age may pre-register to vote using this form. If you fail to check either of these boxes, this form will be returned to you. If you checked NO to either of these statements, do not complete this form.

**Box 3:** If you are registering to vote for the first time in Rhode Island by mail or if someone else turns this form in for you, it is **REQUIRED** that you provide your driver's license number or state ID number issued by the RI Department of Motor Vehicles (DMV). If you do not have either, you must provide the last 4 digits of your Social Security Number. If you do not provide the above information or it cannot be verified, you will be required to provide identification on an election official before voting. Acceptable forms of identification are on the Board of Elections website at <http://www.elections.ri.gov> or contact your local Board of Canvassers (see reverse side of this form).

**Box 5:** A person may have only one legal residence. You must register from your legal residence. A post office box or rural route may only be used as a "Mailing Address" in Box 6.

**Box 9:** If you want to affiliate to vote, choose a party. If you leave Box 9 blank, you will be listed as unaffiliated.

**Box 10:** You must SIGN and DATE the registration form. If you fail to sign and date the form, it will be returned to you.

**Box 11:** If you are updating your voter registration because you legally changed your name, enter your previous legal name.

**Box 12:** If you are updating your voter registration because of an address change, enter your previous address, **even if out-of-state.**

You will receive an acknowledgement receipt of this voter registration form within 3 weeks. If you do not receive it, contact your local Board of Canvassers (see reverse side for list). For questions and deadlines relating to this form, visit the Board of Elections website at <http://www.elections.ri.gov> or contact your local Board of Canvassers (see reverse side for list).

(This form may be reproduced)

<b>1. Check Boxes that Apply:</b> <input type="checkbox"/> New Voter Registration <input type="checkbox"/> Address Change <input type="checkbox"/> Party Change <input type="checkbox"/> Name Change				
<b>2.</b> I am a U.S. Citizen and resident of Rhode Island. <input type="checkbox"/> Yes <input type="checkbox"/> No		<b>3.</b> RI driver's license or ID Number: <input style="width: 150px;" type="text"/>		
I am at least 16 years of age. (You must be at least 18 years of age to vote.) <input type="checkbox"/> Yes <input type="checkbox"/> No		If you do not have a RI driver's license or ID, enter last 4 digits of your social security number: <input style="width: 100px;" type="text"/>		
If you checked NO to either of these statements, do not complete this form.				
<b>4.</b> Last Name <input style="width: 150px;" type="text"/>		Suffix (if any) <input style="width: 100px;" type="text"/>	First Name <input style="width: 150px;" type="text"/>	
		Middle Name (or initial) <input style="width: 100px;" type="text"/>		
<b>5.</b> Home Address (Do not enter a post office box) <input style="width: 150px;" type="text"/>		Apt. <input style="width: 50px;" type="text"/>	City/Town <input style="width: 100px;" type="text"/>	State <b>RI</b>
		ZIP Code <input style="width: 50px;" type="text"/>		
<b>6.</b> Mailing Address (If different from Box 5) <input style="width: 150px;" type="text"/>		Apt. <input style="width: 50px;" type="text"/>	City/Town <input style="width: 100px;" type="text"/>	State <input style="width: 50px;" type="text"/>
		ZIP Code <input style="width: 50px;" type="text"/>		
<b>7.</b> Date of Birth (mm/dd/yyyy) <input style="width: 100px;" type="text"/>		<b>8.</b> Phone No./ E-mail Address (optional) <input style="width: 150px;" type="text"/>		<b>9.</b> Party Affiliation: <input type="checkbox"/> Democrat <input type="checkbox"/> Moderate
Month    Day    Year				<input type="checkbox"/> Republican <input type="checkbox"/> Unaffiliated <input type="checkbox"/> Other <input style="width: 50px;" type="text"/>
<b>10. I swear or affirm that:</b> - I am not incarcerated in a correctional facility upon a felony conviction. - I am not presently judged "mentally incompetent" to vote by a court of law. - The information I have provided is true to the best of my knowledge under penalty of perjury. If I have provided false information, I may be fined, imprisoned, or (if not a U.S. citizen) deported from or refused entry into the United States.			<i>Official Use For Barcode</i>	
<b>PLEASE SIGN FULL NAME OR PLACE MARK BELOW</b>				
<input style="width: 150px; height: 40px;" type="text"/>			<b>Are you interested in working at the polls? (check box below)</b> <input type="checkbox"/>	
			<b>Date:</b> <input style="width: 100px;" type="text"/> (mm/dd/yyyy) <b>Signed</b>	
<b>Warning:</b> If you sign this form and know it to be false, you can be convicted and fined up to \$5,000 or jailed up to 10 years.				
<b>11. PREVIOUS NAME</b> (if different from Box 4) <input style="width: 150px;" type="text"/>		<b>12. PREVIOUS ADDRESS OF REGISTRATION</b> (City/Town, State, ZIP & County) <input style="width: 150px;" type="text"/>		

Return Address

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



Postage  
Required Post  
Office will not  
deliver  
without proper  
postage.

Mail To: **BOARD OF CANVASSERS**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\*\*\*\*\*FOLD HERE & TAPE AT TOP\*\*\*\*\*

**INSTRUCTIONS FOR MAILING THE VOTER REGISTRATION FORM**

An applicant who chooses to mail his/her voter registration form shall do so in the following manner:

1. Fold the form at the dotted line and tape the bottom to the top of the form.
2. From the list below, locate the address of the board of canvassers in the city or town in which you are registering to vote and insert that address in the appropriate space beneath "Mail To: BOARD OF CANVASSERS" on the addressed side of the voter registration form. Insert your return address in the space provided.

**NOTICE:** *It is against the law for anyone to interfere with your privacy in registering to vote or in choosing a political party. If you believe someone has interfered with your right to register or not register, or with your privacy in making this decision, or in choosing a political party, you may file a complaint with the State Board of Elections, 50 Branch Avenue, Providence, Rhode Island 02904.*

**LOCAL BOARDS OF CANVASSERS**

- |  |  |  |   |
|--|--|--|---|
| Barrington Town Hall, 283 County Rd.,<br>Barrington, RI 02806                | Exeter Town Hall, 675 Ten Rod Rd.,<br>Exeter, RI 02822                   | New Shoreham Town Hall, PO Drawer,<br>220 Block Island, RI 02807                       | Smithfield Town Hall, 64 Farnum Pike,<br>Smithfield, RI 02917           |
| Bristol Town Hall, 10 Court St.,<br>Bristol, RI 02809                        | Foster Town Hall, 181 Howard Hill Rd.,<br>Foster, RI 02825               | Newport City Hall, 43 Broadway,<br>Newport, RI 02840                                   | S. Kingstown Town Hall, 180 High St.,<br>Wakefield, RI 02879            |
| Burrillville Town Hall, 105 Harrisville<br>Main St., Harrisville, RI 02830   | Glocester Town Hall 1145 Putnam Pike<br>PO Drawer B, Glocester, RI 02814 | N. Kingstown Town Hall, 80 Boston<br>Neck Rd., North Kingstown, RI 02852               | Tiverton Town Hall, 343 Highland Rd.,<br>Tiverton, RI 02878             |
| Central Falls City Hall, 580 Broad St.,<br>Central Falls, RI 02863           | Hopkinton Town Hall, 1 Town House<br>Rd., Hopkinton, RI 02833            | North Providence Town Hall, 2000<br>Smith St., North Providence, RI 02911              | Warren Town Hall, 514 Main St., Warren,<br>RI 02885                     |
| Charlestown Town Hall, 4540 S. County<br>Trail, Charlestown, RI 02813        | Jamestown Town Hall, 93 Narragansett<br>Ave., Jamestown, RI 02835        | North Smithfield Municipal Annex, 575<br>Smithfield Rd., North Smithfield, RI<br>02896 | Warwick City Hall, 3275 Post Rd.,<br>Warwick, RI 02886                  |
| Coventry Town Hall, 1670 Flat River<br>Rd., Coventry, RI 02816               | Johnston Town Hall, 1385 Hartford<br>Ave., Johnston, RI 02919            | Pawtucket City Hall, 137 Roosevelt<br>Ave., Pawtucket, RI 02860                        | W. Greenwich Town Hall 280 Victory<br>Highway, W. Greenwich, RI 02817   |
| Cranston City Hall, 869 Park Ave.,<br>Cranston, RI 02910                     | Lincoln Town Hall, 100 Old River Rd.,<br>PO Box 100, Lincoln, RI 02865   | Portsmouth Town Hall, 2200 East Main<br>Rd., Portsmouth, RI 02871                      | West Warwick Town Hall, 1170 Main St.,<br>West Warwick, RI 02893        |
| Cumberland Town Hall, 45 Broad St.,<br>Cumberland, RI 02864                  | Little Compton Town Hall, PO Box 226,<br>Little Compton, RI 02837        | Providence City Hall, 25 Dorrance St.,<br>Providence, RI 02903                         | Westerly Town Hall, 45 Broad St.,<br>Westerly, RI 02891                 |
| East Greenwich Town Hall, PO Box 111,<br>East Greenwich, RI 02818            | Middletown Town Hall, 350 East Main<br>Rd., Middletown, RI 02842         | Richmond Town Hall, 5 Richmond<br>Townhouse Rd., Wyoming, RI 02898                     | Woonsocket City Hall, P.O. Box B,<br>169 Main St., Woonsocket, RI 02895 |
| East Providence City Hall,<br>145 Taunton Ave.,<br>East Providence, RI 02914 | Narragansett Town Hall, 25 Fifth Ave.,<br>Narragansett, RI 02882         | Scituate Town Hall, PO Box 328, North<br>Scituate, RI 02857                            |   |

**Voter Registration Questions May Be Addressed To:**

Rhode Island Board of Elections  
50 Branch Avenue  
Providence, RI 02904  
elections@elections.ri.gov