



DEBORAH DEVAUX  
CHAIR

# The Commonwealth of Massachusetts

## HEALTH POLICY COMMISSION

50 MILK STREET, 8TH FLOOR  
BOSTON, MASSACHUSETTS 02109  
(617) 979-1400

DAVID M. SELTZ  
EXECUTIVE DIRECTOR

### OFFICE OF PATIENT PROTECTION

(800) 436-7757 (PHONE)  
(617) 624-5046 (FAX)

## 2023 Insurance Open Enrollment Waiver Information and Instructions

Massachusetts and federal law limit when you can buy certain health insurance plans. Some people may meet special conditions, called qualifying events, like moving, getting married, or having a baby, and can buy insurance at that time. Others must buy insurance during the open enrollment periods.

The open enrollment period for 2023 health insurance plans ended on January 23, 2023. **If you are a Massachusetts resident and missed the open enrollment period, then you might qualify for a waiver of the open enrollment period if you meet certain criteria.** You may use this form to request a waiver to enroll in health insurance coverage outside of open enrollment. OPP expects to accept waiver requests from January 24, 2023 through mid-November 2023. The next open enrollment period is currently scheduled to begin on November 1<sup>st</sup>, 2023 for coverage beginning January 2024.

- You may qualify for a waiver if you meet applicable eligibility criteria and (for example):
  - You are uninsured and did not intentionally forgo enrollment in health insurance; or
  - You lost insurance coverage but did not find out until after two months (about 60 days) had passed.
- **You must first apply for coverage and be turned down for a Special Enrollment Period before you can apply for a waiver.** You can apply for insurance online through the Health Connector at [www.MAhealthconnector.org](http://www.MAhealthconnector.org), by calling 877-MA-ENROLL. Check the Connector's website for availability of designated walk-in centers. You may also apply with the free assistance of a state trained specialist called a Certified Application Counselor or Navigator; find assistance here: <https://my.mahealthconnector.org/enrollment-assisters>. Or, you may purchase coverage directly through a health insurance company, agent, or broker.
- You may qualify for subsidized insurance through the Health Connector or MassHealth. If your family's income is less than 300% of the federal poverty level, different enrollment rules may apply and you might be able to enroll without a waiver from this office. Contact the Health Connector for more information.
- Individuals and families with higher incomes may also qualify for premium assistance like subsidies, but must enroll during the designated open enrollment period, qualify for a special enrollment period, or apply for this waiver.
- You may not need a waiver if:
  - You lost insurance coverage recently (usually within the past two months); or
  - You are a small business owner buying insurance for your business; or

Questions? Call 800-436-7757 or visit [www.mass.gov/hpc/opp](http://www.mass.gov/hpc/opp)

- You are applying for MassHealth or subsidized insurance; or
- You have experienced a qualifying or triggering event (marriage, moved, birth, etc.).

Please note that this form is not an application for health insurance; in fact, you must first apply for health insurance and be denied before completing this form. **If your waiver request is approved, you must then complete the application process with the health insurance company or agent to which you originally applied.** You will not have health insurance until the insurance company, health insurance broker, or Health Connector accepts your complete application and you pay your premium.



**To apply for a waiver, you will need both:**

This completed Enrollment Waiver form; AND

**A copy of the letter or notice denying your enrollment to purchase health insurance**

Please mail or fax your completed Enrollment Waiver form AND the notice denying your application to purchase health insurance to:

**Health Policy Commission  
Office of Patient Protection  
50 Milk Street, 8<sup>th</sup> Floor  
Boston, MA 02109  
Fax: 617-624-5046**

### Important Phone Numbers

- If you have questions about this form or the waiver process, please call the Office of Patient Protection (OPP) at 800-436-7757. You may also contact OPP by email at [HPC-OPP@state.ma.us](mailto:HPC-OPP@state.ma.us). Please note that communications via email are not secure. OPP will include the minimum amount of information necessary in emails if you consent to email communication on the form below.
- If you have questions about open enrollment rules or health insurance laws and regulations, please call the Division of Insurance at 617-521-7794.
- If you have any questions about whether you are eligible for certain health insurance programs or subsidies, you can call the following places for information:
  - MassHealth, 800-841-2900
  - The Health Connector, [MAhealthconnector.org](http://MAhealthconnector.org) or 877-MA-ENROLL (877-623-6765)
  - A local Enrollment Assister may be located at your local hospital or community health center or find one here: <https://my.mahealthconnector.org/enrollment-assisters>.

### About Waivers for Tax Penalties

If you are seeking a waiver of the **tax penalty for being uninsured, do not use this form.** Instead, visit the Massachusetts Department of Revenue's website, <https://www.mass.gov/how-to/learn-how-to-appeal-the-health-care-penalty>, to appeal the Massachusetts tax penalty. The Health Connector's website has additional information: <https://www.mahealthconnector.org/learn/tools-resources/individuals-families>.



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## 2023 REQUEST FOR WAIVER TO PURCHASE HEALTH INSURANCE

Please complete every question on this form and include any additional information you would like the Office of Patient Protection to consider. The Office of Patient Protection may call any of the persons listed on the form to verify the information or may ask you to provide additional information.

Please note that this form is not an application for health insurance. You will not have health insurance until your complete application is accepted and you pay your premium. **Generally, your premium must be paid by the 23<sup>rd</sup> of the month for coverage to begin by the 1<sup>st</sup> of the following month.** For example, for an effective coverage date of March 1<sup>st</sup>, you must enroll and make a payment by February 23<sup>rd</sup>.

1. Your Name	
2. Your full address (Please be sure to include city, state and zip code)	
3. Phone Number	
4. Email Address	
5. How did you hear about OPP?	
6. Preferred method of communication	Choose one: By phone, regular mail or email <input type="checkbox"/> <b>ONLY</b> by phone or regular mail <input type="checkbox"/> <b>NOTE: Communications via email are not secure. OPP will include the minimum amount of information necessary in emails and will only email you with information pertaining to your waiver application.</b>
7. How long have you been a Massachusetts resident?	

<p>8. Do you have health insurance now?</p>	<p>_____ Yes _____ No</p>								
<p>9. Have you had health insurance within the past year?</p>	<p>_____ Yes _____ No</p>								
<p>10. How did you get this Insurance?</p>	<p>Check one:</p> <p><input type="checkbox"/> Employer <input type="checkbox"/> Family Member</p> <p><input type="checkbox"/> Health Connector <input type="checkbox"/> COBRA/ mini COBRA</p> <p><input type="checkbox"/> MassHealth <input type="checkbox"/> Other: _____</p> <p><input type="checkbox"/> Directly from the Insurance Company</p> <p>Name of health insurance company: _____</p> <p>Date insurance ended: _____</p> <p>Reason insurance ended: _____</p> <p>_____</p>								
<p>11. Who do you want to include on the health plan?</p>	<p>_____ Self only _____ Self and following family members:</p> <table border="0" style="width: 100%;"> <tr> <td style="width: 60%;">Name</td> <td style="width: 40%;">Relationship to you</td> </tr> <tr> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> </tr> </table> <p>Attach additional sheet if necessary for additional family members.</p>	Name	Relationship to you	_____	_____	_____	_____	_____	_____
Name	Relationship to you								
_____	_____								
_____	_____								
_____	_____								
<p>12. Will you be purchasing insurance through the Health Connector?</p>	<p>_____ Yes _____ No</p>								
<p>13. Health insurance plan that you want to buy, if applicable</p>	<p>Name of insurance company/plan:</p> <p>_____</p>								
<p>14. Did you receive a notice from the insurance company, the Health Connector or an agent telling you that you cannot enroll without a waiver?</p>	<p>_____ Yes (Please enclose a copy with this request)</p> <p>_____ No (<b>If no, your request is incomplete and cannot be processed.</b>)</p> <p>If you attempted to complete an on-line application for health insurance and did not receive a denial notice by mail, then please print out the web page or email which says you do not qualify and include it with this application.</p>								



**AUTHORIZATION TO REFER CASE TO ANOTHER STATE AGENCY:**

With your permission, OPP may refer this case, including all medical records and medical information submitted to OPP, to the Health Connector, MassHealth, or another state agency. By selecting “yes”, you acknowledge that other state agencies may not be covered by the same privacy laws, and that they may be able to further share the information that is given to them.

- Yes, I give my permission to OPP to refer my case to another state agency.
- No, I do not give my permission to OPP to refer my case to another state agency.

**SIGNATURE AND CERTIFICATION:**

*(this document must be signed by the purchasing individual or parent of minor child under the age of 18)*

I \_\_\_\_\_, hereby request a waiver of the requirement that I wait until  
(Print name)  
the next open enrollment to purchase health insurance. I swear that the information provided in this application is true and accurate to the best of my knowledge.

\_\_\_\_\_  
Signature of applicant

Date: \_\_\_\_\_

I certify, under the penalty of perjury, that I did not intentionally forgo enrollment into coverage for which I was eligible.

\_\_\_\_\_  
Signature of applicant

Date: \_\_\_\_\_

**WHAT TO SEND AND WHERE TO SEND IT**

Mail this completed Request for Waiver form **AND a copy of the letter or notice that told you that you cannot enroll in health coverage without a waiver to:**

**Health Policy Commission  
Office of Patient Protection  
50 Milk Street, 8<sup>th</sup> Floor  
Boston, MA 02109**

Or fax the completed Request for Waiver form and notice to **617-624-5046**.

Send the Request form only (pages 3-6). You do not need to send the instruction pages (pages 1-2).

The Office of Patient Protection will respond to your request in writing **within 30 days**; there is not an expedited option. You can reach the Office of Patient Protection at 800-436-7757. You may also contact the Office of Patient Protection by email at [HPC-OPP@state.ma.us](mailto:HPC-OPP@state.ma.us) with questions, but we cannot accept waiver applications by email. Please **do not** send your Request for Waiver form or any personal health information to this email address because communications via email are not secure.