Attestation Of Information Provided At Enrollment

I have applied for insurance coverage during the special enrollment period.
The Qualifying Life Event that I indicated on my application is identified by the appropriate checked/selected box below.

Qualifying Life Event (Select One)			
☐	Loss of Minimum Essential Coverage (MEC)	☐	Released from jail or prison
☐	Permanently moved to or within California	☐	Lost a dependent or no longer considered a dependent
☐	Gained citizenship or lawful presence	☐	Returned from active duty military service
☐	Had a baby, adopted a child, or fostered a child	☐	Other (e.g. Change of income (APTC Change)
☐	Got married or entered into a domestic partnership	☐	None of the above

Select the option which applies to your situation:

☐	I have evidence of my Qualifying Life Event and will provide it to Covered CA by the requested date.
☐	I cannot obtain a document to verify the Qualifying Life Event. I will provide to Covered CA a written letter signed under penalty of perjury, called an attestation of information, describing my qualifying life event and why I do not have the required documents.

I know that I must report any changes to information on the application. For example I must report a new address, a new member of the household, or a change in income.

I certify (or declare) under the penalty of perjury, under the laws of the State of California, that what I stated above is true and correct.

This means that I have understood all of the questions on the health insurance application and provided true and correct answers to such questions to the best of my knowledge. Where I do not have personal knowledge of an answer I have made every reasonable attempt to verify (or confirm) the information with someone who has personal knowledge of the answer.

I acknowledge that if I am not truthful, I know that there may be a civil and/or criminal penalty of perjury (under California Penal Code Section 126, perjury is punishable by imprisonment for up to four years).

I know that all information disclosed on the application will be used to determine eligibility of every person applying for health insurance on the application. The information will be kept private as required by federal and California law.

I know that I must tell Covered California or the County Social Services Office about anything that changes from what I have provided on the application.

By entering my full name below, I agree that this signature shall have the same effect as if I signed the application by my own hand.

Applicant's Case #: _____

Applicant's Name: _____ (Last, First)

Applicant's Signature: _____ Date: _____