Minimum Essential Coverage

Fax to: 949-334-3478 [24 hrs/day]
or Email to: marc@nocobra.com

Date: ____________________

Case #: ______________________________________   Last 4 of SS#: ____________________

Primary Contact Name: ____

Phone Number: ____

Address on File: ____

____

To whom it may concern,

I, ____ do **NOT** have employer sponsored coverage or government coverage outside of Covered California, or **if my employer provides coverage, it is MORE THAN 9.5% of my income**. Please accept this as a "Minimum Essential Coverage" statement to satisfy the outstanding requirements for my existing Covered California health insurance application (see case# above).

Check all that apply:

- ☐ My Employer offers me health insurance for just myself.
- ☐ My Employer offers me health insurance for myself and my dependent(s).
- ☐ My Employer offers me health insurance at an affordable premium for myself, but to add my dependent(s) to my GROUP COVERAGE, it is **more than 9.5% of my income** to enroll.
- ☐ My GROUP COVERAGE would cost me **more than 9.5% of my income** if I elected to enroll.

X ____

Signature