Covered California
P.O. Box 989725
West Sacramento, CA 95798-9725

COVERED CALIFORNIA

Case Number: | | | | | | | | | | |

Your destination for affordable health insurance, including Medi-Cal

Attestation of Income, No Documentation Available

I, | | | | | | | | | | | | | | | | | | | | | | | | |

(first name)

| | | | | | | | | | | | | | | | | | | | | | | | | |

(middle name)

| | | | | | | | | | | | | | | | | | | | | | | | | |

(last name)

attest that my household's projected annual income for the benefit year in which I will receive financial assistance for my health plan is $ | | | , | | | . | |

(annual income)

- I acknowledge that the information provided on this form will only be used for purposes of eligibility determination for financial assistance. Covered California will keep this information private, as required by federal and California law.

- I understand that I must report income changes to Covered California within 30 days of the change because it may affect the amount of premium assistance (or tax credits) or the level of cost-sharing reduction for which I may qualify.

- I understand that if I receive too much premium assistance (or tax credits) during the benefit year, I will have to pay some or all of the excess premium assistance back to the Internal Revenue Service (IRS) when I file my federal income tax return for the benefit year.

- I declare under the penalty of perjury, under the laws of the state of California, that what I stated above is true and correct.

Applicant's Signature: _____ Date: | | / | | / | | | |

MM *DD* *YYYY*

Send your form in one of the following ways:

Electronic Submission
For faster processing upload this document directly to your online account at CoveredCA.com

Fax
(888) 329-3700

Mail
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P.O. Box 989725
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