

# Application for Health Insurance



Your destination for affordable health insurance, including Medi-Cal



## See Inside

Things to know	1
Application	2-19
Attachments A-F	20-27
Frequently Asked Questions	28-32

Covered California is the place where individuals and families can get affordable health insurance. With just one application, you'll find out if you qualify for free or low-cost health insurance, including Medi-Cal.

**The state of California created Covered California™ to help you and your family get health insurance.**

Having health insurance can give you peace of mind and help make it possible for you to stay healthy. With insurance, you'll know you and your family can get health care when you need it.

**Use this application to see what insurance choices you qualify for:**

- Free or low-cost insurance from Medi-Cal
  - Low-cost insurance for pregnant women through Access for Infants and Mothers (AIM)
  - Affordable private health insurance plans
  - Help paying for your health insurance
- ➔ You may qualify for a free or low-cost program even if you earn as much as \$92,000 a year for a family of 4.
- ➔ You can use this application to apply for anyone in your family, even if they already have insurance now.

**Apply faster through Covered California at CoveredCA.com**

Or call: 1-800-300-1506 (TTY: 1-888-889-4500)  
You can call Monday to Friday, 8 a.m. to 6 p.m. and Saturday, 8 a.m. to 5 p.m.

## You can get this application in other languages

Español	1-800-300-0213
繁體字	1-800-300-1533
Tiếng Việt	1-800-652-9528
한국어	1-800-738-9116
Tagalog	1-800-983-8816
Русский	1-800-778-7695
Հայերեն	1-800-996-1009
فارسی	1-800-921-8879
ភាសាខ្មែរ	1-800-906-8528
Hmoob	1-800-771-2156
العربية	1-800-826-6317

Call 1-800-300-1506 to get this application in other formats such as large print.

# Things to know

## What you need to know when you apply

- Social Security numbers for applicants who are U.S. citizens, or document information for immigrants with satisfactory status who need insurance. Proof of citizenship or immigration status is required only for applicants.
  - Employer and income information for everyone in your family.
  - Your federal tax information. For example, the person who files taxes as head of household and the dependents claimed on your taxes.
  - Information about health insurance that you or any family member gets through a job.
- ➔ We ask about income and other information to make sure you and your family get the most benefits possible.
- ➔ **We keep your information private and secure, as required by law.** We'll use your information only to see if you qualify for health insurance.
- ➔ Families that include immigrants can apply. You can apply for your child even if you aren't eligible for coverage. Applying for your eligible child won't affect your immigration status or chances of becoming a permanent resident or citizen.
- ➔ If you don't file taxes, you can still qualify for free or low-cost insurance through Medi-Cal.
- ➔ If you are a federally recognized American Indian or Alaska Native who is getting services from an Indian Health Services' funded tribal health program or urban Indian health program, you may still qualify for health insurance through Covered California.

## Apply faster online

Apply online at **CoveredCA.com**. It's safe, secure, and fast – and you will get results sooner!

## When you're done

Send your completed and signed application to:

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

- ➔ **If you don't have all the information we ask for, sign and send in your application anyway.** We can call you to help you finish your application.

## Get help with this application

We're here to help you! You can get help at no cost.

- **Online:** **CoveredCA.com**
- **Phone:** Call our Customer Service Center at **1-800-300-1506** (TTY: 1-888-889-4500). The call is free. You can call Monday to Friday, 8 a.m. to 6 p.m., and Saturday, 8 a.m. to 5 p.m.
- **In person:** We have trained Certified Enrollment Counselors and Certified Insurance Agents who can help you. For a list of Certified Enrollment Counselors and Certified Insurance Agents near where you live or work, or a list of county social services offices near you, visit **CoveredCA.com** or call **1-800-300-1506** (TTY: 1-888-889-4500). This help is free!
- If you have a disability or other need, we can provide assistance with completing this application at no cost to you. You can go to your local county social services office in person or call our Customer Service Center at **1-800-300-1506** (TTY: 1-888-889-4500).

## Need help?

Call Covered California at **1-800-300-1506** (TTY: 1-888-889-4500). The call is free. You can call Monday to Friday, 8 a.m. to 6 p.m. and Saturday, 8 a.m. to 5 p.m. Or visit **CoveredCA.com**.



# Start application here (use blue or black ink only)

## Step 1:

### Tell us about the adult who will be our main contact for this application

First name \_\_\_\_\_ Middle name \_\_\_\_\_ Last name \_\_\_\_\_ Suffix (examples: Sr., Jr., III, IV) \_\_\_\_\_

Home address \_\_\_\_\_ Apartment # \_\_\_\_\_

City (home address) \_\_\_\_\_ State \_\_\_\_\_ ZIP code \_\_\_\_\_ County \_\_\_\_\_

Check here if you do not have a home address. You must give us a mailing address below.

Check here if your mailing address is the same as your home address.  
**If it is not the same**, you must give us your mailing address below:

Mailing address or P.O. Box (if different from home address) \_\_\_\_\_ Apartment # \_\_\_\_\_

City (mailing address) \_\_\_\_\_ State \_\_\_\_\_ ZIP code \_\_\_\_\_ County \_\_\_\_\_

Best phone number to reach you  Home  Cell  Work  
Number: (        )        –        Other phone number  Home  Cell  Work  
Number: (        )        –

What language should we write to you in? \_\_\_\_\_ What language do you want us to speak to you in? \_\_\_\_\_

How would you like to get information about this application?

Phone  Mail  Email Email address: \_\_\_\_\_

Infants less than one year old are eligible for Medi-Cal if their mother was on Medi-Cal or AIM at the time of delivery. You do not need to fill out an application to get Medi-Cal for an infant born to a mother with Medi-Cal or AIM at the time of delivery. Call your county social services office when your baby is born to make sure your baby is covered. Or fill out the information below.

Optional: If the following information is provided, the infant may be automatically eligible for Medi-Cal.  
You do not have to fill out Step 2 of this application for the infant.

Are you applying for a child less than 1 year old?  Yes  No

If yes, did the child's mother have Medi-Cal or AIM when the child was born?  Yes  No

If yes, will the child's mother be listed on this application?  Yes  No

If yes, the mother is Person # \_\_\_\_\_ on this application

If no, what is the mother's first and last name? \_\_\_\_\_

Please provide the mother's Medi-Cal number, AIM number, or SSN \_\_\_\_\_



0460687

## ¿Preguntas?

Llame a Covered California al **1-800-300-1506** (TTY: 1-888-889-4500). La llamada es gratuita.  
Usted puede llamar de lunes a viernes de 8 a.m. a 6 p.m. y los sábados de 8 a.m. a 5 p.m.  
O visite **CoveredCA.com**.



## Step 2:

## Tell us about yourself and your family

Your income and family size help us decide what programs you qualify for. With this information, we can make sure everyone gets the best coverage possible.

### You must include these people on this application:

- Your spouse
  - Your children who live with you
  - All parents living in the home with their child
  - Anyone on your federal income tax return, if you file one. You don't need to file taxes to apply for health insurance.
- ★ If you are claimed as a dependent on someone else's tax return, you must include all members of the tax filing household that claimed you, and any family members living with you.
- ★ Anyone else who lives with you – for example, a boyfriend, girlfriend, or roommate – will need to file his or her **own** application if they want health insurance.

### Complete Step 2 for each person in your family. Start with yourself!

- To apply for more than four people on this application, **make a copy of pages 6–8** for each additional person.
- We'll keep all your information private, as required by law. We'll use personal information only to see if you qualify for health insurance. You do not need to provide the immigration status or Social Security number (SSN) for those in your family who are not applying for health insurance.

### Person 1 Tell us about yourself

First name	Middle name	Last name	Suffix (examples: Sr., Jr., III, IV)	Relationship to you <b>Self</b>
Are you: <input type="checkbox"/> Male <input type="checkbox"/> Female		Are you: <input type="checkbox"/> Single <input type="checkbox"/> Never married <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Registered domestic partner <input type="checkbox"/> Separated <input type="checkbox"/> Widowed		
Date of birth (month / day / year)		Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes</i> , how many babies are expected? _____ What is the expected delivery date? _____		

### Applying for health insurance *Even if you have insurance now, you might find better coverage or lower costs.*

▶ Are you applying for health insurance for yourself?  **Yes** *If yes*, answer the questions below.  **No** *If no*, go to the next page.

★ Social Security number (SSN) ____ - ____ - ____	If you do not have an SSN, what is the reason? <input type="checkbox"/> Adoption Taxpayer Identification Number (ATIN) _____ <input type="checkbox"/> Individual Taxpayer Identification Number (ITIN) _____ <input type="checkbox"/> Religious exemption <input type="checkbox"/> I do not qualify for an SSN
--	---

★ You must provide a Social Security number (SSN) if you or a family member wish to apply for health insurance, or if you file taxes as head of household. We use Social Security numbers (SSNs) to check income and other information. Even if you are not applying, giving your SSN will help us review your application faster.

If someone who is applying does not have an SSN and would like help getting one, call **1-800-300-1506** (TTY: 1-888-889-4500) or visit **CoveredCA.com**.

**Person 1** continued on next page 

## Need help?

Call Covered California at **1-800-300-1506** (TTY: 1-888-889-4500). The call is free. You can call Monday to Friday, 8 a.m. to 6 p.m. and Saturday, 8 a.m. to 5 p.m. Or visit **CoveredCA.com**.



## Step 2:

## Person 1 (continued)

**Federal income tax information** *If you don't file taxes, you can still qualify for free or low-cost insurance through Medi-Cal. We will keep your information private. We will use your information only to decide if you qualify for health insurance.*

Are you going to file taxes for the **benefit** year?

Yes  No

*If yes*, how will you file?

Head of household  Single

Married filing jointly  Married filing separately

Does anyone claim you as a dependent on their taxes?  Yes  No

*If yes*, who?

Person # \_\_\_\_\_ on this application

This person is a parent without custody

This person is a parent without custody who is not listed on this application

Do you have other health insurance or are you offered insurance through a job?  Yes  No

*If yes*, fill out Attachment B on pages 22 and 23.

Do you have a physical, mental, emotional, or developmental disability?

Yes  No *See FAQ #26 for more information on what it means to have a disability.*

Do you need help with long-term care or home

and community-based services?  Yes  No

Are you a U.S. citizen or U.S. national?  Yes  No

If you are **not** a U.S. citizen or U.S. national, answer these questions:

Do you have satisfactory immigration status?  Yes **To see if you have satisfactory status**, go to Attachment E on page 26 for a list.

*Then write the document information here. In most cases your document ID number will be your Alien Registration Number.*

Document type: \_\_\_\_\_ ID number: \_\_\_\_\_

Country of issuance: \_\_\_\_\_ Expiration date: \_\_\_\_\_

Name as it appears on the document: \_\_\_\_\_

Have you lived in the U.S. since 1996?

Yes  No

Are you, your spouse, or an unmarried dependent child an honorably discharged

veteran or active-duty member of the U.S. armed forces?  Yes  No

Do you receive Medicare benefits?

Yes  No

Did you have a medical expense in the last 3 months that you need help paying for?

Yes  No

Do you live with any children under the age of 19?  Yes  No

*If yes*, do you take care of the child or children?  Yes  No

Are you 18 to 20 years old and a full-time student?  Yes  No

Are you 18 to 26 years old?  Yes  No *If yes*, were you in foster care in any state on your 18th birthday?  Yes  No

Are you 18 years old or younger?  Yes  No How many parents live with you? \_\_\_\_\_

Are you temporarily living out of state?  Yes  No

If you would like to choose a health insurance plan now, check here  and fill out Attachment D on page 25.

**Tell us about your race** *Please tell us about yourself. This information is confidential and will only be used to make sure that everyone has the same access to health care. It will not be used to decide what health insurance you qualify for.*

What is your race? (*Optional: Check all that apply*)

White

Asian Indian

Japanese

Guamanian or

Black or African  
American

Cambodian

Korean

Chamorro

American Indian  
or Alaska Native

Chinese

Laotian

Samoan

Filipino

Vietnamese

Other

Hmong

Native Hawaiian

Are you of Hispanic, Latino, or Spanish origin? (*Optional*)  Yes  No

*If yes*, check which ones:

Mexican, Mexican American, Chicano

Salvadoran  Guatemalan

Cuban  Puerto Rican

Other Hispanic, Latino or Spanish

origin: \_\_\_\_\_

★  Check here if you are a **federally recognized** American Indian or Alaska Native, and fill out Attachment A on pages 20 and 21.

**Person 1** continued on next page 

**¿Preguntas?**

Llame a Covered California al **1-800-300-1506** (TTY: 1-888-889-4500). La llamada es gratuita. Usted puede llamar de lunes a viernes de 8 a.m. a 6 p.m. y los sábados de 8 a.m. a 5 p.m. O visite **CoveredCA.com**.



# Step 2:

## Person 1 (continued)

**Tell us about your current job and how you get money** *Attach an extra page if you need more space.*

Do you work now?  **Yes** *If yes, answer the questions below.*  **No** *If no, go to other income on this page.*

▶ **Where do you work now?** *If you have more jobs, attach another sheet of paper.*

**JOB 1:** How do you get paid?  Hourly: How many hours per week? \_\_\_\_\_  Daily: How many days per week? \_\_\_\_\_  
 Weekly  Every two weeks  Twice a month  Monthly  One-time payment

Employer name (Optional) \_\_\_\_\_ How much do you get paid (before taxes)? \$ \_\_\_\_\_

**JOB 2:** How do you get paid?  Hourly: How many hours per week? \_\_\_\_\_  Daily: How many days per week? \_\_\_\_\_  
 Weekly  Every two weeks  Twice a month  Monthly  One-time payment

Employer name (Optional) \_\_\_\_\_ How much do you get paid (before taxes)? \$ \_\_\_\_\_

▶ **Are you self-employed?**

**JOB 1:** Are you self-employed?  **Yes** *If yes, answer the questions below.*  **No** *If no, go to other income on this page.*

Type of work \_\_\_\_\_ How much *net income* will you get from self-employment this month? Amount: \$ \_\_\_\_\_  
*Net income means the profits left over after expenses are paid. Attachment E on page 26 lists what could be counted.*

**JOB 2:** Are you self-employed?  **Yes** *If yes, answer the questions below.*  **No** *If no, go to other income on this page.*

Type of work \_\_\_\_\_ How much *net income* will you get from self-employment this month? Amount: \$ \_\_\_\_\_  
*Net income means the profits left over after expenses are paid. Attachment E on page 26 lists what could be counted.*

▶ **Do you have other income?** *Other income is money you get from something other than your job. Do not include child support payments, veteran's payments, or Supplemental Security Income (SSI). Go to Attachment E on page 26 to see examples of other income.*

Do you have other income?  **Yes** *If yes, answer the questions below.*  **No** *If no, go to income change on this page.*

Where does this income come from?	How often do you get paid? (check one)	How much?
	<input type="checkbox"/> Hourly: How many hours per week? _____ <input type="checkbox"/> Every two weeks <input type="checkbox"/> Daily: How many days per week? _____ <input type="checkbox"/> Twice a month <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> One-time payment	\$ _____
	<input type="checkbox"/> Hourly: How many hours per week? _____ <input type="checkbox"/> Every two weeks <input type="checkbox"/> Daily: How many days per week? _____ <input type="checkbox"/> Twice a month <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> One-time payment	\$ _____

▶ **Does your income change from month to month?** *If it does, answer the two questions below.*

What do you expect your total income to be **this** year? (Optional) \$ \_\_\_\_\_ If you expect your income to change **next** year, what will the new total income be? (Optional) \$ \_\_\_\_\_

▶ **Do you have deductions?** *If you pay for certain things that can be deducted on a federal income tax return, telling us about them may lower the cost of health insurance. Do not include self-employment expenses. Attachment E on page 26 lists other types of deductions.*

Do you have deductions?  **Yes** *If yes, answer the questions below.*  **No** *If no, go to the next page.*

Type of deduction	How often do you get or pay for this deduction? (check one)	How much?
<input type="checkbox"/> Alimony paid <input type="checkbox"/> Student loan interest <input type="checkbox"/> Other	<input type="checkbox"/> Hourly: How many hours per week? _____ <input type="checkbox"/> Every two weeks <input type="checkbox"/> Daily: How many days per week? _____ <input type="checkbox"/> Twice a month <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> One-time payment	\$ _____
<input type="checkbox"/> Alimony paid <input type="checkbox"/> Student loan interest <input type="checkbox"/> Other	<input type="checkbox"/> Hourly: How many hours per week? _____ <input type="checkbox"/> Every two weeks <input type="checkbox"/> Daily: How many days per week? _____ <input type="checkbox"/> Twice a month <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> One-time payment	\$ _____

### Need help?

Call Covered California at **1-800-300-1506** (TTY: 1-888-889-4500). The call is free. You can call Monday to Friday, 8 a.m. to 6 p.m. and Saturday, 8 a.m. to 5 p.m. Or visit **CoveredCA.com**.



## Step 2:

**Person 2** Tell us about **the next person** living in your home.  
**If you have more than four people** on this application, make a copy of pages 6–8 for each additional person.

First name Middle name Last name Suffix (examples: Sr., Jr., III, IV) Relationship to you

- Check here if this person's home address is the same as the main contact's home address.  
**If it is not the same**, you must give us this person's home address below:

Home address Apartment #

City (home address) State ZIP code County

- Check here if this person does not have a home address. You must give us a mailing address below.

- Check here if this person's mailing address is the same as the main contact's mailing address.  
**If it is not the same**, you must give us this person's mailing address below:

Mailing address or P.O. Box (if different from home address) Apartment #

City (mailing address) State ZIP code County

Best phone number to reach this person  Home  Cell  Work Other phone number  Home  Cell  Work  
Number: ( ) – Number: ( ) –

Email address:

What language should we write to this person in? What language does this person want us to speak to him or her in?

Is this person:  Male  Female Is this person:  Single  Never married  Married  Divorced  
 Registered domestic partner  Separated  Widowed

Date of birth (month / day / year) Is this person pregnant?  Yes  No **If yes**, how many babies are expected? \_\_\_\_\_  
What is the expected delivery date? \_\_\_\_\_

**Applying for health insurance** Even if this person has insurance now, you might find better coverage or lower costs.

- Is this person applying for health insurance?  **Yes** **If yes**, answer the questions below.  **No** **If no**, SSN information is optional.

★ Social Security number (SSN)

— — — — — — — — — —

If this person does not have an SSN, what is the reason?

- Adoption Taxpayer Identification Number (ATIN) \_\_\_\_\_  
 Individual Taxpayer Identification Number (ITIN) \_\_\_\_\_  
 Religious exemption  Child less than 1 year old  Does not qualify for an SSN

**Federal income tax information** If this person didn't file taxes, he or she can still qualify for free or low-cost insurance through Medi-Cal. We will keep the information private and use it only to decide if the person qualifies for health insurance.

Is this person going to file taxes for the **benefit** year?  
 Yes  No **If yes**, how will he or she file?  
 Head of household  Single  Dependent  
 Married filing jointly  Married filing separately

Does anyone claim this person as a dependent on their taxes?  Yes  No  
**If yes**, who?  
 Person # \_\_\_\_\_ on this application  
 This person is a parent without custody  
 This person is a parent without custody who is not listed on this application

Person 2 continued on next page 

**¿Preguntas?**

Llame a Covered California al **1-800-300-1506** (TTY: 1-888-889-4500). La llamada es gratuita.  
Usted puede llamar de lunes a viernes de 8 a.m. a 6 p.m. y los sábados de 8 a.m. a 5 p.m.  
O visite **CoveredCA.com**.



## Step 2:

## Person 2 (continued)

Does this person have other health insurance or is this person offered insurance through a job?  Yes  No

*If yes*, fill out Attachment B on pages 22 and 23.

Do you have a physical, mental, emotional, or developmental disability?

Yes  No *See FAQ #26 for more information on what it means to have a disability.*

Do you need help with long-term care or home and

community-based services?  Yes  No

Is this person a U.S. citizen or U.S. national?  Yes  No

If this person is **not** a U.S. citizen or U.S. national, answer these questions:

Does this person have satisfactory immigration status?  Yes **To see if this person has satisfactory status, go to Attachment E on page 26 for a list. Then write the document information here. In most cases your document ID number will be your Alien Registration Number.**

Document type: \_\_\_\_\_ ID number: \_\_\_\_\_

Country of issuance: \_\_\_\_\_ Expiration date: \_\_\_\_\_

Name as it appears on the document: \_\_\_\_\_

Has this person lived in the U.S. since 1996?  Yes  No

Is this person, this person's spouse, or an unmarried dependent child an honorably discharged veteran or active-duty member of the U.S. armed forces?  Yes  No

Does this person receive Medicare benefits?

Yes  No

Did this person have a medical expense in the last 3 months that he or she needs help paying for?  Yes  No

Does this person live with any children under the age of 19?  Yes  No

*If yes*, does this person take care of the child or children?  Yes  No

Is this person 18 to 20 years old and a full-time student?  Yes  No

Is this person 18 to 26 years old?  Yes  No

*If yes*, was this person in foster care in any state on his or her 18th birthday?  Yes  No

Is this person 18 years old or younger?  Yes  No How many parents live with this person? \_\_\_\_\_

Is this person temporarily living out of state?  Yes  No

### Tell us about this person's race

What is this person's race? (*Optional: Check all that apply*)

White

Asian Indian

Japanese

Guamanian or Chamorro

Black or African American

Cambodian

Korean

Samoan

American Indian or Alaska Native

Chinese

Laotian

Other

Filipino

Vietnamese

Hmong

Native Hawaiian

Is this person of Hispanic, Latino, or Spanish origin? (*Optional*)  Yes  No

*If yes*, check which ones:

Mexican, Mexican American, Chicano

Salvadoran  Guatemalan

Cuban  Puerto Rican

Other Hispanic, Latino or Spanish origin: \_\_\_\_\_

★  Check here if this person is a **federally recognized** American Indian or Alaska Native, and fill out Attachment A on pages 20 and 21.

**Person 2** continued on next page 

**Need help?**

Call Covered California at **1-800-300-1506** (TTY: 1-888-889-4500). The call is free. You can call Monday to Friday, 8 a.m. to 6 p.m. and Saturday, 8 a.m. to 5 p.m. Or visit **CoveredCA.com**.





# Step 2:

## Person 2 (continued)

Tell us about this person's current job and how he or she gets money *Attach an extra page if you need more space.*

Does this person work now?  **Yes** *If yes, answer the questions below.*  **No** *If no, go to other income on this page.*

► **Where does this person work now?** *If he or she has more jobs, attach another sheet of paper.*

**JOB 1:** How does this person get paid?  Hourly: How many hours per week? \_\_\_\_\_  Daily: How many days per week? \_\_\_\_\_  
 Weekly  Every two weeks  Twice a month  Monthly  One-time payment

Employer name (Optional)	How much does this person get paid (before taxes)? \$
--------------------------	---

**JOB 2:** How does this person get paid?  Hourly: How many hours per week? \_\_\_\_\_  Daily: How many days per week? \_\_\_\_\_  
 Weekly  Every two weeks  Twice a month  Monthly  One-time payment

Employer name (Optional)	How much does this person get paid (before taxes)? \$
--------------------------	---

► **Is this person self-employed?**

**JOB 1:** Is this person self-employed?  **Yes** *If yes, answer the questions below.*  **No** *If no, go to other income on this page.*

Type of work	How much <i>net income</i> will this person get from self-employment this month? Amount: \$ _____ <i>Net income means the profits left over after expenses are paid. Attachment E on page 26 lists what could be counted.</i>
--------------	--

**JOB 2:** Is this person self-employed?  **Yes** *If yes, answer the questions below.*  **No** *If no, go to other income on this page.*

Type of work	How much <i>net income</i> will this person get from self-employment this month? Amount: \$ _____ <i>Net income means the profits left over after expenses are paid. Attachment E on page 26 lists what could be counted.</i>
--------------	--

► **Does this person have other income?** *Other income is money you get from something other than your job. Go to Attachment E on page 26 to see examples of other income. Do not include child support payments, veteran's payments, or Supplemental Security Income (SSI).*

Does this person have other income?  **Yes** *If yes, answer the questions below.*  **No** *If no, go to income change on this page.*

Where does this income come from?	How often does this person get paid? (check one)	How much?
	<input type="checkbox"/> Hourly: How many hours per week? _____ <input type="checkbox"/> Every two weeks <input type="checkbox"/> Daily: How many days per week? _____ <input type="checkbox"/> Twice a month <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> One-time payment	\$
	<input type="checkbox"/> Hourly: How many hours per week? _____ <input type="checkbox"/> Every two weeks <input type="checkbox"/> Daily: How many days per week? _____ <input type="checkbox"/> Twice a month <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> One-time payment	\$

► **Does this person's income change from month to month?** *If it does, answer the two questions below.*

What do you expect this person's total income to be <b>this</b> year? (Optional) \$	If you expect this person's income to change <b>next</b> year, what will the new total income be? (Optional) \$
---	---

► **Does this person have deductions?** *If this person pays for certain things that can be deducted on a federal income tax return, telling us about them may lower the cost of health insurance. Do not include self-employment expenses. Attachment E on page 26 lists other types of deductions.*

Does this person have deductions?  **Yes** *If yes, answer the questions below.*  **No** *If no, go to the next page.*

Type of deduction	How often does this person get this deduction? (check one)	How much?
<input type="checkbox"/> Alimony paid <input type="checkbox"/> Student loan interest <input type="checkbox"/> Other	<input type="checkbox"/> Hourly: How many hours per week? _____ <input type="checkbox"/> Every two weeks <input type="checkbox"/> Daily: How many days per week? _____ <input type="checkbox"/> Twice a month <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> One-time payment	\$
<input type="checkbox"/> Alimony paid <input type="checkbox"/> Student loan interest <input type="checkbox"/> Other	<input type="checkbox"/> Hourly: How many hours per week? _____ <input type="checkbox"/> Every two weeks <input type="checkbox"/> Daily: How many days per week? _____ <input type="checkbox"/> Twice a month <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> One-time payment	\$

### ¿Preguntas?

Llame a Covered California al **1-800-300-1506** (TTY: 1-888-889-4500). La llamada es gratuita. Usted puede llamar de lunes a viernes de 8 a.m. a 6 p.m. y los sábados de 8 a.m. a 5 p.m. O visite **CoveredCA.com**.



## Step 2:

### Person 3 Tell us about *the next person* living in your home.

First name Middle name Last name Suffix (examples: Sr., Jr., III, IV) Relationship to you

- Check here if this person's home address is the same as the main contact's home address.  
**If it is not the same**, you must give us this person's home address below:

Home address Apartment #

City (home address) State ZIP code County

- Check here if this person does not have a home address. You must give us a mailing address below.

- Check here if this person's mailing address is the same as the main contact's mailing address.  
**If it is not the same**, you must give us this person's mailing address below:

Mailing address or P.O. Box (if different from home address) Apartment #

City (mailing address) State ZIP code County

Best phone number to reach this person  Home  Cell  Work Other phone number  Home  Cell  Work  
Number: ( ) - Number: ( ) -

Email address:

What language should we write to this person in?

What language does this person want us to speak to him or her in?

Is this person:  Male  Female

Is this person:  Single  Never married  Married  Divorced  
 Registered domestic partner  Separated  Widowed

Date of birth (month / day / year)

Is this person pregnant?  Yes  No **If yes**, how many babies are expected? \_\_\_\_\_  
What is the expected delivery date? \_\_\_\_\_

### Applying for health insurance Even if this person has insurance now, you might find better coverage or lower costs.

- Is this person applying for health insurance?  **Yes** **If yes**, answer the questions below.  **No** **If no**, SSN information is optional.

★ Social Security number (SSN)

— — — — —

If this person does not have an SSN, what is the reason?

- Adoption Taxpayer Identification Number (ATIN) \_\_\_\_\_  
 Individual Taxpayer Identification Number (ITIN) \_\_\_\_\_  
 Religious exemption  Child less than 1 year old  Does not qualify for an SSN

### Federal income tax information If this person didn't file taxes, he or she can still qualify for free or low-cost insurance through Medi-Cal. We will keep the information private and use it only to decide if the person qualifies for health insurance.

Is this person going to file taxes for the **benefit** year?

- Yes  No **If yes**, how will he or she file?  
 Head of household  Single  Dependent  
 Married filing jointly  Married filing separately

Does anyone claim this person as a dependent on their taxes?  Yes  No

**If yes**, who?

- Person # \_\_\_\_\_ on this application  
 This person is a parent without custody  
 This person is a parent without custody who is not listed on this application

Person 3 continued on next page 

**Need help?**

Call Covered California at **1-800-300-1506** (TTY: 1-888-889-4500). The call is free. You can call Monday to Friday, 8 a.m. to 6 p.m. and Saturday, 8 a.m. to 5 p.m. Or visit **CoveredCA.com**.



## Step 2:

## Person 3 (continued)

### Applying for health insurance *Even if this person has insurance now, you might find better coverage or lower costs.*

► Is this person applying for health insurance?  **Yes** *If yes, answer the questions below.*  **No** *If no, go to the next page.*

Does this person have other health insurance or is this person offered insurance through a job?  Yes  No  
*If yes, fill out Attachment B on pages 22 and 23.*

Do you have a physical, mental, emotional, or developmental disability?  Yes  No *See FAQ #26 for more information on what it means to have a disability.* Do you need help with long-term care or home and community-based services?  Yes  No

Is this person a U.S. citizen or U.S. national?  Yes  No

If this person is **not** a U.S. citizen or U.S. national, answer these questions:

Does this person have satisfactory immigration status?  Yes  No **To see if this person has satisfactory status, go to Attachment E on page 26 for a list. Then write the document information here. In most cases your document ID number will be your Alien Registration Number.**

Document type: \_\_\_\_\_ ID number: \_\_\_\_\_

Country of issuance: \_\_\_\_\_ Expiration date: \_\_\_\_\_

Name as it appears on the document: \_\_\_\_\_

Has this person lived in the U.S. since 1996?  Yes  No

Is this person, this person's spouse, or an unmarried dependent child an honorably discharged veteran or active-duty member of the U.S. armed forces?  Yes  No

Does this person receive Medicare benefits?  
 Yes  No

Did this person have a medical expense in the last 3 months that he or she needs help paying for?  Yes  No

Does this person live with any children under the age of 19?  Yes  No

*If yes, does this person take care of the child or children?*  Yes  No

Is this person 18 to 20 years old and a full-time student?  Yes  No

Is this person 18 to 26 years old?  Yes  No

*If yes, was this person in foster care in any state on his or her 18th birthday?*  Yes  No

Is this person 18 years old or younger?  Yes  No How many parents live with this person? \_\_\_\_\_

Is this person temporarily living out of state?  Yes  No

### Tell us about this person's race

What is this person's race? (*Optional: Check all that apply*)

- |   |                                       |  |  |
|---|---------------------------------------|--|--|
| <input type="checkbox"/> White                            | <input type="checkbox"/> Asian Indian | <input type="checkbox"/> Japanese        | <input type="checkbox"/> Guamanian or Chamorro |
| <input type="checkbox"/> Black or African American        | <input type="checkbox"/> Cambodian    | <input type="checkbox"/> Korean          | <input type="checkbox"/> Samoan                |
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Chinese      | <input type="checkbox"/> Laotian         | <input type="checkbox"/> Other _____           |
|   | <input type="checkbox"/> Filipino     | <input type="checkbox"/> Vietnamese      |  |
|   | <input type="checkbox"/> Hmong        | <input type="checkbox"/> Native Hawaiian |  |

Is this person of Hispanic, Latino, or Spanish origin? (*Optional*)  Yes  No

*If yes, check which ones:*

- |  |
|--|
| <input type="checkbox"/> Mexican, Mexican American, Chicano              |
| <input type="checkbox"/> Salvadoran <input type="checkbox"/> Guatemalan  |
| <input type="checkbox"/> Cuban <input type="checkbox"/> Puerto Rican     |
| <input type="checkbox"/> Other Hispanic, Latino or Spanish origin: _____ |

★  Check here if this person is a **federally recognized** American Indian or Alaska Native, and fill out Attachment A on pages 20 and 21.

**Person 3** continued on next page 

## ¿Preguntas?

Llame a Covered California al **1-800-300-1506** (TTY: 1-888-889-4500). La llamada es gratuita. Usted puede llamar de lunes a viernes de 8 a.m. a 6 p.m. y los sábados de 8 a.m. a 5 p.m. O visite **CoveredCA.com**.



# Step 2:

## Person 3 (continued)

Tell us about this person's current job and how he or she gets money *Attach an extra page if you need more space.*

Does this person work now?  **Yes** *If yes, answer the questions below.*  **No** *If no, go to other income on this page.*

► **Where does this person work now?** *If he or she has more jobs, attach another sheet of paper.*

**JOB 1:** How does this person get paid?  Hourly: How many hours per week? \_\_\_\_\_  Daily: How many days per week? \_\_\_\_\_  
 Weekly  Every two weeks  Twice a month  Monthly  One-time payment

Employer name (Optional)	How much does this person get paid (before taxes)? \$
--------------------------	---

**JOB 2:** How does this person get paid?  Hourly: How many hours per week? \_\_\_\_\_  Daily: How many days per week? \_\_\_\_\_  
 Weekly  Every two weeks  Twice a month  Monthly  One-time payment

Employer name (Optional)	How much does this person get paid (before taxes)? \$
--------------------------	---

► **Is this person self-employed?**

**JOB 1:** Is this person self-employed?  **Yes** *If yes, answer the questions below.*  **No** *If no, go to other income on this page.*

Type of work	How much <i>net income</i> will this person get from self-employment this month? Amount: \$ _____ <i>Net income means the profits left over after expenses are paid. Attachment E on page 26 lists what could be counted.</i>
--------------	--

**JOB 2:** Is this person self-employed?  **Yes** *If yes, answer the questions below.*  **No** *If no, go to other income on this page.*

Type of work	How much <i>net income</i> will this person get from self-employment this month? Amount: \$ _____ <i>Net income means the profits left over after expenses are paid. Attachment E on page 26 lists what could be counted.</i>
--------------	--

► **Does this person have other income?** *Other income is money you get from something other than your job. Go to Attachment E on page 26 to see examples of other income. Do not include child support payments, veteran's payments, or Supplemental Security Income (SSI).*

Does this person have other income?  **Yes** *If yes, answer the questions below.*  **No** *If no, go to income change on this page.*

Where does this income come from?	How often does this person get paid? (check one)	How much?
	<input type="checkbox"/> Hourly: How many hours per week? _____ <input type="checkbox"/> Every two weeks <input type="checkbox"/> Daily: How many days per week? _____ <input type="checkbox"/> Twice a month <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> One-time payment	\$
	<input type="checkbox"/> Hourly: How many hours per week? _____ <input type="checkbox"/> Every two weeks <input type="checkbox"/> Daily: How many days per week? _____ <input type="checkbox"/> Twice a month <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> One-time payment	\$

► **Does this person's income change from month to month?** *If it does, answer the two questions below.*

What do you expect this person's total income to be <b>this</b> year? (Optional) \$	If you expect this person's income to change <b>next</b> year, what will the new total income be? (Optional) \$
---	---

► **Does this person have deductions?** *If this person pays for certain things that can be deducted on a federal income tax return, telling us about them may lower the cost of health insurance. Do not include self-employment expenses. Attachment E on page 26 lists other types of deductions.*

Does this person have deductions?  **Yes** *If yes, answer the questions below.*  **No** *If no, go to the next page.*

Type of deduction	How often does this person get this deduction? (check one)	How much?
<input type="checkbox"/> Alimony paid <input type="checkbox"/> Student loan interest <input type="checkbox"/> Other	<input type="checkbox"/> Hourly: How many hours per week? _____ <input type="checkbox"/> Every two weeks <input type="checkbox"/> Daily: How many days per week? _____ <input type="checkbox"/> Twice a month <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> One-time payment	\$
<input type="checkbox"/> Alimony paid <input type="checkbox"/> Student loan interest <input type="checkbox"/> Other	<input type="checkbox"/> Hourly: How many hours per week? _____ <input type="checkbox"/> Every two weeks <input type="checkbox"/> Daily: How many days per week? _____ <input type="checkbox"/> Twice a month <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> One-time payment	\$

**Need help?**

Call Covered California at **1-800-300-1506** (TTY: 1-888-889-4500). The call is free. You can call Monday to Friday, 8 a.m. to 6 p.m. and Saturday, 8 a.m. to 5 p.m. Or visit **CoveredCA.com**.



## Step 2:

### Person 4 Tell us about **the next person** living in your home.

First name Middle name Last name Suffix (examples: Sr., Jr., III, IV) Relationship to you

- Check here if this person's home address is the same as the main contact's home address.  
**If it is not the same**, you must give us this person's home address below:

Home address Apartment #

City (home address) State ZIP code County

- Check here if this person does not have a home address. You must give us a mailing address below.

- Check here if this person's mailing address is the same as the main contact's mailing address.  
**If it is not the same**, you must give us this person's mailing address below:

Mailing address or P.O. Box (if different from home address) Apartment #

City (mailing address) State ZIP code County

Best phone number to reach this person  Home  Cell  Work Other phone number  Home  Cell  Work  
Number: ( ) - Number: ( ) -

Email address:

What language should we write to this person in?

What language does this person want us to speak to him or her in?

Is this person:  Male  Female

Is this person:  Single  Never married  Married  Divorced  
 Registered domestic partner  Separated  Widowed

Date of birth (month / day / year)

Is this person pregnant?  Yes  No **If yes**, how many babies are expected? \_\_\_\_\_  
What is the expected delivery date? \_\_\_\_\_

#### Applying for health insurance Even if this person has insurance now, you might find better coverage or lower costs.

- Is this person applying for health insurance?  **Yes** **If yes**, answer the questions below.  **No** **If no**, SSN information is optional.

★ Social Security number (SSN)

— — — — —

If this person does not have an SSN, what is the reason?

- Adoption Taxpayer Identification Number (ATIN) \_\_\_\_\_  
 Individual Taxpayer Identification Number (ITIN) \_\_\_\_\_  
 Religious exemption  Child less than 1 year old  Does not qualify for an SSN

#### Federal income tax information If this person didn't file taxes, he or she can still qualify for free or low-cost insurance through Medi-Cal. We will keep the information private and use it only to decide if the person qualifies for health insurance.

Is this person going to file taxes for the **benefit** year?

- Yes  No **If yes**, how will he or she file?  
 Head of household  Single  Dependent  
 Married filing jointly  Married filing separately

Does anyone claim this person as a dependent on their taxes?  Yes  No

**If yes**, who?

- Person # \_\_\_\_\_ on this application  
 This person is a parent without custody  
 This person is a parent without custody who is not listed on this application

Person 4 continued on next page 

**¿Preguntas?**

Llame a Covered California al **1-800-300-1506** (TTY: 1-888-889-4500). La llamada es gratuita. Usted puede llamar de lunes a viernes de 8 a.m. a 6 p.m. y los sábados de 8 a.m. a 5 p.m. O visite **CoveredCA.com**.



## Step 2:

## Person 4 (continued)

### Applying for health insurance *Even if this person has insurance now, you might find better coverage or lower costs.*

► Is this person applying for health insurance?  **Yes** *If yes, answer the questions below.*  **No** *If no, go to the next page.*

Does this person have other health insurance or is this person offered insurance through a job?  Yes  No  
*If yes, fill out Attachment B on pages 22 and 23.*

Do you have a physical, mental, emotional, or developmental disability?  Yes  No *See FAQ #26 for more information on what it means to have a disability.* Do you need help with long-term care or home and community-based services?  Yes  No

Is this person a U.S. citizen or U.S. national?  Yes  No

If this person is **not** a U.S. citizen or U.S. national, answer these questions:

Does this person have satisfactory immigration status?  Yes **To see if this person has satisfactory status, go to Attachment E on page 26 for a list. Then write the document information here. In most cases your document ID number will be your Alien Registration Number.**

Document type: \_\_\_\_\_ ID number: \_\_\_\_\_

Country of issuance: \_\_\_\_\_ Expiration date: \_\_\_\_\_

Name as it appears on the document: \_\_\_\_\_

Has this person lived in the U.S. since 1996?  Yes  No

Is this person, this person's spouse, or an unmarried dependent child an honorably discharged veteran or active-duty member of the U.S. armed forces?  Yes  No

Does this person receive Medicare benefits?  
 Yes  No

Did this person have a medical expense in the last 3 months that he or she needs help paying for?  Yes  No

Does this person live with any children under the age of 19?  Yes  No

*If yes, does this person take care of the child or children?*  Yes  No

Is this person 18 to 20 years old and a full-time student?  Yes  No

Is this person 18 to 26 years old?  Yes  No

*If yes, was this person in foster care in any state on his or her 18th birthday?*  Yes  No

Is this person 18 years old or younger?  Yes  No How many parents live with this person? \_\_\_\_\_

Is this person temporarily living out of state?  Yes  No

### Tell us about this person's race

What is this person's race? (*Optional: Check all that apply*)

- |   |                                       |  |  |
|---|---------------------------------------|--|--|
| <input type="checkbox"/> White                            | <input type="checkbox"/> Asian Indian | <input type="checkbox"/> Japanese        | <input type="checkbox"/> Guamanian or Chamorro |
| <input type="checkbox"/> Black or African American        | <input type="checkbox"/> Cambodian    | <input type="checkbox"/> Korean          | <input type="checkbox"/> Samoan                |
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Chinese      | <input type="checkbox"/> Laotian         | <input type="checkbox"/> Other _____           |
|   | <input type="checkbox"/> Filipino     | <input type="checkbox"/> Vietnamese      |  |
|   | <input type="checkbox"/> Hmong        | <input type="checkbox"/> Native Hawaiian |  |

Is this person of Hispanic, Latino, or Spanish origin? (*Optional*)  Yes  No

*If yes, check which ones:*

- |  |
|--|
| <input type="checkbox"/> Mexican, Mexican American, Chicano              |
| <input type="checkbox"/> Salvadoran <input type="checkbox"/> Guatemalan  |
| <input type="checkbox"/> Cuban <input type="checkbox"/> Puerto Rican     |
| <input type="checkbox"/> Other Hispanic, Latino or Spanish origin: _____ |

★  Check here if this person is a **federally recognized** American Indian or Alaska Native, and fill out Attachment A on pages 20 and 21.

**Person 4** continued on next page 

**Need help?**

Call Covered California at **1-800-300-1506** (TTY: 1-888-889-4500). The call is free. You can call Monday to Friday, 8 a.m. to 6 p.m. and Saturday, 8 a.m. to 5 p.m. Or visit **CoveredCA.com**.



# Step 2:

## Person 4 (continued)

**Tell us about this person's current job and how he or she gets money** *Attach an extra page if you need more space.*

Does this person work now?  **Yes** *If yes, answer the questions below.*  **No** *If no, go to other income on this page.*

► **Where does this person work now?** *If he or she has more jobs, attach another sheet of paper.*

**JOB 1:** How does this person get paid?  Hourly: How many hours per week? \_\_\_\_\_  Daily: How many days per week? \_\_\_\_\_  
 Weekly  Every two weeks  Twice a month  Monthly  One-time payment

Employer name (Optional) \_\_\_\_\_ How much does this person get paid (before taxes)? \$ \_\_\_\_\_

**JOB 2:** How does this person get paid?  Hourly: How many hours per week? \_\_\_\_\_  Daily: How many days per week? \_\_\_\_\_  
 Weekly  Every two weeks  Twice a month  Monthly  One-time payment

Employer name (Optional) \_\_\_\_\_ How much does this person get paid (before taxes)? \$ \_\_\_\_\_

► **Is this person self-employed?**

**JOB 1:** Is this person self-employed?  **Yes** *If yes, answer the questions below.*  **No** *If no, go to other income on this page.*

Type of work \_\_\_\_\_ How much *net income* will this person get from self-employment this month? Amount: \$ \_\_\_\_\_  
*Net income means the profits left over after expenses are paid. Attachment E on page 26 lists what could be counted.*

**JOB 2:** Is this person self-employed?  **Yes** *If yes, answer the questions below.*  **No** *If no, go to other income on this page.*

Type of work \_\_\_\_\_ How much *net income* will this person get from self-employment this month? Amount: \$ \_\_\_\_\_  
*Net income means the profits left over after expenses are paid. Attachment E on page 26 lists what could be counted.*

► **Does this person have other income?** *Other income is money you get from something other than your job. Go to Attachment E on page 26 to see examples of other income. Do not include child support payments, veteran's payments, or Supplemental Security Income (SSI).*

Does this person have other income?  **Yes** *If yes, answer the questions below.*  **No** *If no, go to income change on this page.*

Where does this income come from?	How often does this person get paid? (check one)	How much?
	<input type="checkbox"/> Hourly: How many hours per week? _____ <input type="checkbox"/> Every two weeks <input type="checkbox"/> Daily: How many days per week? _____ <input type="checkbox"/> Twice a month <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> One-time payment	\$ _____
	<input type="checkbox"/> Hourly: How many hours per week? _____ <input type="checkbox"/> Every two weeks <input type="checkbox"/> Daily: How many days per week? _____ <input type="checkbox"/> Twice a month <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> One-time payment	

► **Does this person's income change from month to month?** *If it does, answer the two questions below.*

What do you expect this person's total income to be **this** year? (Optional) \$ \_\_\_\_\_ If you expect this person's income to change **next** year, what will the new total income be? (Optional) \$ \_\_\_\_\_

► **Does this person have deductions?** *If this person pays for certain things that can be deducted on a federal income tax return, telling us about them may lower the cost of health insurance. Do not include self-employment expenses. Attachment E on page 26 lists other types of deductions.*

Does this person have deductions?  **Yes** *If yes, answer the questions below.*  **No** *If no, go to the next page.*

Type of deduction	How often does this person get this deduction? (check one)	How much?
<input type="checkbox"/> Alimony paid <input type="checkbox"/> Student loan interest <input type="checkbox"/> Other	<input type="checkbox"/> Hourly: How many hours per week? _____ <input type="checkbox"/> Every two weeks <input type="checkbox"/> Daily: How many days per week? _____ <input type="checkbox"/> Twice a month <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> One-time payment	\$ _____
<input type="checkbox"/> Alimony paid <input type="checkbox"/> Student loan interest <input type="checkbox"/> Other	<input type="checkbox"/> Hourly: How many hours per week? _____ <input type="checkbox"/> Every two weeks <input type="checkbox"/> Daily: How many days per week? _____ <input type="checkbox"/> Twice a month <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> One-time payment	

### ¿Preguntas?

Llame a Covered California al **1-800-300-1506** (TTY: 1-888-889-4500). La llamada es gratuita. Usted puede llamar de lunes a viernes de 8 a.m. a 6 p.m. y los sábados de 8 a.m. a 5 p.m. O visite **CoveredCA.com**.



## Step 3:

## Please read and sign this application

### You can choose an authorized representative

- ★ You can choose someone to be your “authorized representative.” An authorized representative is a person you allow to see your application and talk with us about it now and in the future.

Name of authorized representative

Address

Apartment #

City

State

ZIP code

County

By signing, you allow this person to sign your application, to get official information about this application, and to act for you on all future matters with this agency.

Your signature 

Date

### Privacy statement

This application is for health insurance through Covered California or for benefits through the Department of Health Care Services (DHCS). The personal and medical information you provide on it is private and confidential. Covered California or the Department of Health Care Services (DHCS) need it to identify you and the other people on this application and to administer our programs.

We will share your information with other state, federal and local agencies, contractors, health plans and programs only to enroll you in a plan or program, or to administer programs, and with other state and federal agencies as required by law.

- You must answer all of the questions on this application unless they are marked “optional.” If your application is missing anything that we require we will contact you to get it. ➔ **If you do not provide it**, we will not be able to make a decision on your application. You may have to submit a new application, or you may not be able to get health insurance through Covered California, or your application for benefits may be denied.
- In most cases, you have the right to see personal information about you that is in federal and state records. You can see it in an alternative format (such as large print) if you need that.

For more information or to see **Covered California** records, contact the Privacy Officer at:

Covered California  
Attn: Privacy Officer  
P.O. Box 989725  
West Sacramento, CA 95798-9725

Phone: 1-800-300-1506  
TTY: 1-888-889-4500

For the **Department of Health Care Services**, contact the Information Protection Unit at:

P.O. Box 997413, MS 4721  
Sacramento, CA  
95899-7413


Phone: 1-866-866-0602  
TTY: 1-877-735-2929

These state and federal laws give us the right to collect and keep the information on the application:

Covered CA: 42 U.S.C. § 18031; CA Government Code §§100502(k) and 100503(a)

DHCS: CA Welfare and Institutions. Code § 14011 and Article 3, Chapters 5 and 7, Parts 2 and 3, Division 9

We must give you this Privacy Statement under CA Civil Code section 1798.17. You can see Covered California's Privacy Policy at CoveredCA.com. See DHCS' Notice of Privacy Practices at dhcs.ca.gov.

**Step 3** continued on next page 

**Need help?**

Call Covered California at **1-800-300-1506** (TTY: 1-888-889-4500). The call is free. You can call Monday to Friday, 8 a.m. to 6 p.m. and Saturday, 8 a.m. to 5 p.m. Or visit **CoveredCA.com**.





## Step 3:

## Please read and sign this application *(continued)*

### Your rights and responsibilities

- The information I gave on this application is true as far as I know. I know that I may be subject to a penalty if I do not tell the truth.
- I understand that the information I give will be used only to see if those in my family who are applying for health insurance will qualify.
- I understand that Covered California and the Medi-Cal program will keep my information private, as the law requires. For more information, or access to personal information in records maintained by Covered California and the Medi-Cal program, I can contact the Privacy Officer at **1-800-300-1506** (TTY: 1-888-889-4500).
- I understand that to be eligible for Medi-Cal, I am required to apply for other income or benefits to which I or any member of my household is entitled, unless he or she has good cause for not doing so. Examples of such income or benefits are pensions, government benefits, retirement income, veterans' benefits, annuities, disability benefits, Social Security benefits (also called OASDI or Old Age, Survivors, and Disability Insurance), and unemployment benefits. But such income or benefits do not include public assistance benefits, such as CalWORKs or CalFresh. If I have a question about a possible source of income, I can call Covered California at **1-800-300-1506** (TTY: 1-888-889-4500) for help.
- I know that I must tell Covered California or my county social services office about changes to anything I wrote on this application. To report changes, I can call Covered California at **1-800-300-1506** (TTY: 1-888-889-4500) or visit **CoveredCA.com**. Or, I can call my county social services office.
- I know that Covered California must not discriminate against me or anyone on this application because of race, color, national origin, religion, age, sex, sexual orientation, marital status, veteran's status or disability. If I think Covered California has discriminated against me, including the failure to provide reasonable accommodations as required under state and federal law, I can make a complaint by visiting [www.hhs.gov/ocr/office/file](http://www.hhs.gov/ocr/office/file) or <http://oag.ca.gov/contact/general-comment-question-or-complaint-form>. If I believe that Covered California has discriminated against me or anyone else on this application in connection with a Medi-Cal eligibility determination, I can also file a complaint with the Department of Health Care Services, Office of Civil Rights by calling **1-916-440-7370** (TTY: 1-916-440-7399).
- I understand that any changes in my information or information of any member(s) in the applicant's household may affect the eligibility of other members of the household.
- I confirm that no one applying for health insurance on this application is confined, after the disposition of charges (judgment), in a jail, prison, or similar penal institution or correctional facility. However, all inmates may apply for Medi-Cal regardless of their incarceration status.
- I understand that I must report income changes to Covered California because it may affect the amount of premium assistance (or tax credits) that I may be eligible to receive. I also understand if I receive too much premium assistance (or tax credits) during the benefit year, I will have to repay the extra premium assistance back to the IRS when I file my federal income taxes for the benefit year.
- I give my permission to Covered California to check other agencies' computer records to verify citizenship, satisfactory immigration status, tax information, and other information related only to eligibility to see if I and other people on this application qualify for health insurance.

#### **If someone on the application qualifies for Medi-Cal:**

- I know that if Medi-Cal pays for a medical expense, any money I or anyone on this application get from other health insurance or legal settlements related to that expense will go to Medi-Cal as payment for the expense until the expense is paid in full.

#### **For parents whose child or children qualify for Medi-Cal:**

- I know I will be asked to help the agency that collects medical support from any parent on this application who does not live with the child and does not send support for the child. If I think that helping will harm me or my children, I can tell the Medi-Cal program and I will not have to help.

*Your rights and responsibilities continued on next page* 

## ¿Preguntas?

Llame a Covered California al **1-800-300-1506** (TTY: 1-888-889-4500). La llamada es gratuita. Usted puede llamar de lunes a viernes de 8 a.m. a 6 p.m. y los sábados de 8 a.m. a 5 p.m. O visite **CoveredCA.com**.



## Step 3:

## Please read and sign this application *(continued)*

### Your rights and responsibilities *(continued)*

#### Your right to appeal:

- If I think Covered California or the Medi-Cal program has made a mistake, I can appeal its decision. To **appeal** means to tell someone at Covered California or the Medi-Cal program that I think its decision is wrong and ask for a fair review of the action.
- I know that I can find out how to appeal by calling **1-800-300-1506** (TTY: 1-888-889-4500).
- I know that I must file an appeal within 90 days of the decision.
- I know that I can represent myself or have someone else represent me in my appeal, such as an authorized representative, a friend, a relative, or a lawyer.
- I know that if I need help, someone at Covered California, the Medi-Cal program, or the county social services office can explain my case to me.

#### Renewal of insurance

To make it easier to continue to get health insurance in future years, I agree to allow Covered California to use computer sources, such as the IRS, to check my income. If the sources show I am still eligible, my insurance coverage can be renewed for another 12 months and I won't have to fill out a renewal form or send other paperwork.

I understand that if I choose not to allow Covered California to use computer sources, I must complete a renewal packet every 12 months in order to continue my health insurance.

I agree to allow Covered California or the Medi-Cal program to check my information for:

- 5 years  4 years  3 years  2 years  1 year

#### OR

- I do not want Covered California to check my tax returns at renewal.


### Declaration and signature *This is required.*

I declare under penalty of perjury that what I say below is true and correct.

- I understood all questions on this application and gave true and correct answers as far as I know. Where I did not know the answer myself, I made every reasonable attempt to confirm the answer with someone who did know.
- I know that if I do not tell the truth on this application, there may be a civil or criminal penalty for perjury that may include up to four years in jail. (See California Penal Code Section 126.)
- I know that the information on this application will be used to decide if the people who are applying qualify for health insurance. Covered California will keep the information private, as required by federal and California law.
- I agree to notify Covered California by calling **1-800-300-1506** (TTY: 1-888-889-4500) or visiting **CoveredCA.com** if anything changes on this application for any person applying for health insurance.

*Signature of applicant or authorized representative:*

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

**Step 3** continued on next page 

## Need help?

Call Covered California at **1-800-300-1506** (TTY: 1-888-889-4500). The call is free. You can call Monday to Friday, 8 a.m. to 6 p.m. and Saturday, 8 a.m. to 5 p.m. Or visit **CoveredCA.com**.



## Step 3:

## Please read and sign this application *(continued)*

Complete this section if you are a Covered California certified individual helping someone fill out this application.

I certify that as a Certified Enrollment Counselor, Certified Insurance Agent, or Certified Plan-Based Enroller, I helped the applicant complete this application and that this service was free of charge. I also certify that I gave true and correct answers to all questions on this application as far as I know. I explained to the applicant, in easy-to-understand language, the risk to the applicant of providing inaccurate information, and the applicant understood the explanation.

<input type="checkbox"/> Certified Enrollment Counselor Name: _____	CEC number
<input type="checkbox"/> Certified Enrollment Entity Name: _____	CEE number
<input type="checkbox"/> Certified Insurance Agent Name: _____	License number
<input type="checkbox"/> Certified Plan-Based Enroller      Plan: _____ Name: _____	Certification number

Certified individual's signature:  \_\_\_\_\_ Date: \_\_\_\_\_

*The state will not compensate the Covered California Certified Enrollment Entity unless the Certified Enrollment Counselor fills out this section completely and correctly when the application is submitted.*

## Step 4:

## Mailing information and checklist

### Mail your signed application to:

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

### Did you remember to:

- Tell us about everyone in your family and household, even if they don't need insurance?  
See page 3 for the list of whom to include.
- Ask your employer about any job-related insurance you may qualify for?
- **Sign** this application on **page 17**? If you chose an authorized representative, also sign page 15.

## A few more questions *(Optional)*

1. **Would you like to be considered for all Medi-Cal programs?**  Yes  No

*There are other Medi-Cal programs for people 65 years old or older, people with a disability or people with special health care needs.*

*If you check yes, we will contact you to get information about your property and assets.*

2. **Have you had any recent changes in your life that made you want to apply for health insurance?**

*If yes, check all that apply.*

- |   |  |
|---|--|
| <input type="checkbox"/> Moved to California                                | <input type="checkbox"/> No longer incarcerated                                |
| <input type="checkbox"/> Gained citizenship or lawful presence              | <input type="checkbox"/> Newly eligible for premium assistance                 |
| <input type="checkbox"/> Loss of health insurance                           | <input type="checkbox"/> Applying for Medi-Cal                                 |
| <input type="checkbox"/> Gained dependent (by birth, marriage, or adoption) | <input type="checkbox"/> Federally recognized American Indian or Alaska Native |
|   | <input type="checkbox"/> Other   |

When did this life event occur? *(month, day, year)* \_\_\_\_\_

## ¿Preguntas?

Llame a Covered California al **1-800-300-1506** (TTY: 1-888-889-4500). La llamada es gratuita. Usted puede llamar de lunes a viernes de 8 a.m. a 6 p.m. y los sábados de 8 a.m. a 5 p.m. O visite **CoveredCA.com**.



## How did you hear about Covered California?

Check all that apply.

- Outreach and education program     TV ad     Radio ad     Email     Mailer  
 Internet search     Social media (e.g., Facebook, Twitter, etc.)     Web     Mobile app  
 Billboard     Transit     Sign in retail store     Friend or family     Brochure  
 Certified Insurance Agent     Certified Enrollment Counselor     Employer     Church  
 CoveredCA.com website     Pharmacy     Provider/Hospital     Government Office  
 Other \_\_\_\_\_

## Need more information about other programs?

Beginning January 1, 2014, would you and or your household like to share the information you just provided in a referral to your local Health and Human Services Agency for other programs? Families that include immigrants can apply. You can apply for your child even if you aren't eligible for coverage. Applying for your eligible child won't affect your immigration status or chances of becoming a permanent resident or citizen.

To apply for nutrition or cash assistance before January 1, 2014, visit [benefitscal.org](http://benefitscal.org). Or to apply in person, call 1-877-847-3663 for a list of places near where you live or work.

For benefits after January 1, 2014, check which programs you want a referral for:

- CalFresh** *A program that helps people pay for food. Benefits are renewed monthly on a debit card that can be used to buy most foods at many markets and stores. It is also known as the Supplemental Nutrition Assistance Program (SNAP). Visit [www.calfresh.ca.gov](http://www.calfresh.ca.gov) for more information.*
- CalWORKs** *A program that gives cash assistance and support services to low income families with children to help pay for housing, food and other necessary expenses.*

You may also find more information about these programs online:

### Access for Infants and Mothers (AIM)

*A program that helps pregnant women get health care*  
[aim.ca.gov](http://aim.ca.gov)

### Child Health and Disability Prevention (CHDP)

*A preventive program that delivers periodic health assessments and services to low-income children*  
[dhcs.ca.gov/services/chdp](http://dhcs.ca.gov/services/chdp)

### Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

*A Medi-Cal program for children and young adults under the age of 21 – it allows for regular checkups to identify health care needs, followed by diagnosis and treatment when necessary*  
[dhcs.ca.gov/services/Pages/EPSDT.aspx](http://dhcs.ca.gov/services/Pages/EPSDT.aspx)

### Family Planning, Access, Care, Treatment (Family PACT)

*A program that provides no-cost family planning services to low-income men and women, including teens*  
[familypact.org](http://familypact.org)

### In-Home Supportive Services Program (IHSS)

*A program that will help pay for services provided to you so that you can remain safely in your own home*  
[cdss.ca.gov/agedblinddisabled/pg1296.htm](http://cdss.ca.gov/agedblinddisabled/pg1296.htm)

### Women, Infants, and Children (WIC)

*A nutrition program for pregnant women, new mothers, and children under the age of 5*  
[wicworks.ca.gov](http://wicworks.ca.gov)



★ If you need to tell us about more than four people who have other health insurance, make a copy of this page.

## Tell us about the health insurance you have now

Answer these questions for everyone who needs help paying for health insurance.

Does anyone have other health insurance now? Other insurance may include COBRA, employer-sponsored insurance, Peace Corps, retiree health plan, TRICARE/CHAMPUS, veterans health program, Indian Health Service, tribal health program, urban Indian health program, or other health insurance not listed here. You may have additional health insurance that you do not have to tell us about. The following are **examples** of additional coverage (not considered minimum essential coverage) you do not have to tell us about: flex savings plans, health savings accounts, disability insurance, or insurance available in another country. **If you have private health insurance you bought on your own, check the box for "Other health insurance."**

Also tell us if anyone has insurance that is not listed above.

- Yes** *If yes*, fill in this page. If you need more space, attach another sheet of paper.  
 **No** *If no*, go to page 23.

Name <i>First, middle, last</i>	What type? <i>(choose one)</i>	
<b>Person 1:</b> Has this person been offered affordable full coverage health insurance for January 2014? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> COBRA <input type="checkbox"/> Employer-sponsored insurance <input type="checkbox"/> Peace Corps <input type="checkbox"/> Retiree health plan <input type="checkbox"/> TRICARE/CHAMPUS	<input type="checkbox"/> Veterans health program <input type="checkbox"/> Indian Health Service <input type="checkbox"/> Tribal health program <input type="checkbox"/> Urban Indian health program <input type="checkbox"/> Other health insurance
<b>Person 2:</b> Has this person been offered affordable full coverage health insurance for January 2014? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> COBRA <input type="checkbox"/> Employer-sponsored insurance <input type="checkbox"/> Peace Corps <input type="checkbox"/> Retiree health plan <input type="checkbox"/> TRICARE/CHAMPUS	<input type="checkbox"/> Veterans health program <input type="checkbox"/> Indian Health Service <input type="checkbox"/> Tribal health program <input type="checkbox"/> Urban Indian health program <input type="checkbox"/> Other health insurance
<b>Person 3:</b> Has this person been offered affordable full coverage health insurance for January 2014? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> COBRA <input type="checkbox"/> Employer-sponsored insurance <input type="checkbox"/> Peace Corps <input type="checkbox"/> Retiree health plan <input type="checkbox"/> TRICARE/CHAMPUS	<input type="checkbox"/> Veterans health program <input type="checkbox"/> Indian Health Service <input type="checkbox"/> Tribal health program <input type="checkbox"/> Urban Indian health program <input type="checkbox"/> Other health insurance
<b>Person 4:</b> Has this person been offered affordable full coverage health insurance for January 2014? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> COBRA <input type="checkbox"/> Employer-sponsored insurance <input type="checkbox"/> Peace Corps <input type="checkbox"/> Retiree health plan <input type="checkbox"/> TRICARE/CHAMPUS	<input type="checkbox"/> Veterans health program <input type="checkbox"/> Indian Health Service <input type="checkbox"/> Tribal health program <input type="checkbox"/> Urban Indian health program <input type="checkbox"/> Other health insurance

Attachment B continued on next page 



## Employer health insurance *Answer these questions for everyone who needs help paying for health insurance.*

★ We need to know about any health insurance you could get through someone's job. You can use Attachment C, Employer Insurance Form, on page 24 to help you complete this section. Answer these questions or use Attachment C **only** if someone in the household qualifies for health insurance from someone's job.

Is anyone on this application offered health insurance by an employer?

*This could be someone else's job, such as a parent's or a spouse's. It could also include COBRA, TRICARE, federal or state employer, private employer, or Peace Corps plans. You may have additional health insurance that you do not have to report to us. The following are examples of additional coverage (not considered minimum essential coverage) you do not have to include: flex savings plan; health savings accounts; disability insurance; insurance available in another country; coverage only for accident; general liability insurance and automobile liability insurance; workers' compensation; benefits for long-term care, nursing home care, home health care, or community-based care; Medicare supplemental health insurance, and restricted coverage of pregnancy-related services under Medi-Cal.*

- Yes** *If yes, answer these questions. If you need more space, attach another sheet of paper.*
- No** *If no, go back to the application to continue.*

Name Name First, middle, last, suffix (for example, Jr., Sr., III, IV)	Employer name (Optional)	This person:	How much does this person pay in monthly premiums?	Does this health plan meet the <i>minimum value standard</i> *?
Person 1:		<input type="checkbox"/> Is enrolled now <input type="checkbox"/> Plans to enroll <i>Start date</i> _____ <input type="checkbox"/> Is not enrolled	\$	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't know
Person 2:		<input type="checkbox"/> Is enrolled now <input type="checkbox"/> Plans to enroll <i>Start date</i> _____ <input type="checkbox"/> Is not enrolled	\$	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't know
Person 3:		<input type="checkbox"/> Is enrolled now <input type="checkbox"/> Plans to enroll <i>Start date</i> _____ <input type="checkbox"/> Is not enrolled	\$	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't know
Person 4:		<input type="checkbox"/> Is enrolled now <input type="checkbox"/> Plans to enroll <i>Start date</i> _____ <input type="checkbox"/> Is not enrolled	\$	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't know

What change will the employer make for the new plan year (if known)?

- Employer won't offer health coverage
- Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the *minimum value standard*.\* (Premium should reflect the discount for wellness programs.)

How much will the employee have to pay in premiums for that plan? \$ \_\_\_\_\_

How often? \_\_\_\_\_

Weekly     Every 2 weeks     Quarterly  
 Monthly     Twice a month     Yearly

Date of change \_\_\_\_\_

\**Minimum value standard* means that a plan pays at least 60% of the total cost of plan benefits provided to the employee. (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

**Go back to the application to continue** 





**This form is only necessary for those who are applying for health insurance through a job.**

It is not necessary for some health insurance programs offered through Covered California, including Medi-Cal. If you are not sure whether or not to use this form, call Covered California to ask: 1-800-300-1506 (TTY: 1-888-880-4500).

If more than one job offers health coverage, use a separate form for each employer.

What change will the employer make for the new plan year (if known)?

- Employer won't offer health coverage
- Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the **minimum value standard**.\* (Premium should reflect the discount for wellness programs.)

How much will the employee have to pay in premiums for that plan? \$ \_\_\_\_\_

How often? \_\_\_\_\_

- Weekly
- Every 2 weeks
- Quarterly
- Monthly
- Twice a month
- Yearly

Date of change \_\_\_\_\_

### ▶ Employee information

★ Fill in your name and Social Security number (SSN) (*optional*). Then make a copy of this page or take the application to your employer. Ask your employer to fill in the rest of the page. If you copy the page, be sure to send it with your application.

<b>Employee:</b> First name	Middle name	Last name	Social Security number (SSN) ( <i>Optional</i> )
_____	_____	_____	____ - ____ - _____

### ▶ Employer information *Ask the employer for this information*

★ **Note for employer:** To complete the Covered California application, we need to know about health insurance that your employee or their dependents might be able to get from you. Please complete the information below, even if your company does not offer health insurance.

<b>Employer name:</b>	Employer Identification Number (EIN)	
_____	____ - ____ - _____	
Employer address	Employer phone number	
_____	_____	
City	State	ZIP code
_____	_____	_____

Who can we contact about employee health coverage at this job?

Phone number	Email address
_____	_____

- We do not offer health insurance.
- This employee does not qualify for coverage under our plan.
- The employee qualifies for coverage under our plan beginning on \_\_\_\_\_ (*start date*).

What's the name of the lowest cost, self-only health plan this employee could enroll in at this job? Consider only those plans that meet the **minimum value standard**\* set by the Federal Patient Protection and Affordable Care Act of 2010. If you're not sure, ask your health insurance issuer.

Name: \_\_\_\_\_

- No plans meet the minimum value standard\*.

How much would the employee have to pay in premiums for the lowest cost? \$ \_\_\_\_\_

How often? \_\_\_\_\_

- Weekly
- Every 2 weeks
- Quarterly
- Monthly
- Twice a month
- Yearly
- Other \_\_\_\_\_

\***Minimum value standard** means that a plan pays at least 60% of the total cost of plan benefits provided to the employee. (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

**Go back to the application to continue** ▶▶

## ¿Preguntas?

Llame a Covered California al **1-800-300-1506** (TTY: 1-888-889-4500). La llamada es gratuita. Usted puede llamar de lunes a viernes de 8 a.m. a 6 p.m. y los sábados de 8 a.m. a 5 p.m. O visite **CoveredCA.com**.



# Attachment D:

# Choose your health insurance plan

★ If you need to tell us about more than four people who would like to choose a health plan, **make a copy of this page.**

If you think you qualify for Medi-Cal or premium assistance and would like to choose your health insurance plan, write the name or metal tier of the plans you want below. To learn more about private health insurance plans provided by Covered California, visit [CoveredCA.com](http://CoveredCA.com) or call 1-800-300-1506 (TTY: 1-888-889-4500).

To learn more about available Medi-Cal plans in your county, call Health Care Options at 1-800-430-4263 (TTY: 1-800-430-7077), or visit [healthcareoptions.dhcs.ca.gov](http://healthcareoptions.dhcs.ca.gov). To see if you qualify for Medi-Cal or premium assistance, look at the chart on page 27.

▶ Medi-Cal and Covered California plans		▶ Covered California plans <i>Only</i>		
Name <i>First, middle, last, suffix</i> <i>(for example, Jr., Sr., III, IV)</i>	Health plan name	Metal tier	Metal number	Plan type
Person 1:		<input type="checkbox"/> Platinum <input type="checkbox"/> Gold <input type="checkbox"/> Silver <input type="checkbox"/> Bronze <input type="checkbox"/> Minimum Coverage Plan		<input type="checkbox"/> EPO <input type="checkbox"/> HMO <input type="checkbox"/> PPO
Person 2:		<input type="checkbox"/> Platinum <input type="checkbox"/> Gold <input type="checkbox"/> Silver <input type="checkbox"/> Bronze <input type="checkbox"/> Minimum Coverage Plan		<input type="checkbox"/> EPO <input type="checkbox"/> HMO <input type="checkbox"/> PPO
Person 3:		<input type="checkbox"/> Platinum <input type="checkbox"/> Gold <input type="checkbox"/> Silver <input type="checkbox"/> Bronze <input type="checkbox"/> Minimum Coverage Plan		<input type="checkbox"/> EPO <input type="checkbox"/> HMO <input type="checkbox"/> PPO
Person 4:		<input type="checkbox"/> Platinum <input type="checkbox"/> Gold <input type="checkbox"/> Silver <input type="checkbox"/> Bronze <input type="checkbox"/> Minimum Coverage Plan		<input type="checkbox"/> EPO <input type="checkbox"/> HMO <input type="checkbox"/> PPO

## Declaration and signature

I declare under penalty of perjury that what I say below is true and correct.

- If I am determined eligible by Covered California to enroll in the plan I selected above, I understand that by signing this page I am entering into a contract with the issuer of that plan.
- I am at least 18 years of age, or I am an emancipated minor, and mentally competent to sign a contract.
- If I am eligible for and enrolling in a Medi-Cal plan, I understand if I want to change my plan, I must call Health Care Options at 1-800-430-4263 (TTY: 1-800-430-7077). Or visit [healthcareoptions.dhcs.ca.gov](http://healthcareoptions.dhcs.ca.gov).
- I understand that every participating health plan has its own rules for resolving disputes or claims, including, but not limited to, any claim asserted by me, my enrolled dependents, heirs, or authorized representatives against a health plan about the membership in the health plan, the delivery of services, medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), or premises liability. I understand that, if I select a health plan that requires binding arbitration to resolve disputes, I accept the use of binding arbitration and give up my right to a jury trial and cannot have the dispute decided in court, except as applicable law provides for judicial review of arbitration proceedings. I understand that the full arbitration provision for each participating health plan, if they have one, is in the health plan's coverage document, which is available online at [CoveredCA.com](http://CoveredCA.com) for my review, or, I can call Covered California for more information. I do not give up my right to a State hearing of any issue, which is subject to the State hearing process.

*Signature of applicant, or responsible party, or authorized representative:*

▶ \_\_\_\_\_ Date: \_\_\_\_\_

**Need help?**

Call Covered California at **1-800-300-1506** (TTY: 1-888-889-4500). The call is free. You can call Monday to Friday, 8 a.m. to 6 p.m. and Saturday, 8 a.m. to 5 p.m. Or visit [CoveredCA.com](http://CoveredCA.com).

