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

Case Number:

Your destination for affordable health insurance, including Medi-Cal

Attestation of Income, No Documentation Available

Please print using CAPITAL LETTERS only

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)*

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- I understand the information provided on this form will only be used to decide if I qualify for financial help. Covered California will keep this information private, as required by law.
- I understand I must report any income changes to Covered California within 30 days. I understand this may change the amount of financial help I get or the level of cost-sharing I qualify for.
- I understand this income attestation is only good for the benefit year I'm applying for. I understand I will need to renew my income attestation each year.
- I understand if I get more tax credits (financial help) than I qualify for, I may need to pay back some or all of the extra amount to the IRS when I file my federal income tax return.
- I declare, under the penalty of perjury under California law, that the information I've given on this form is true and correct.

☐ ***(optional)*** Covered California may update my application with the income amount I list on this form. I understand this may change my eligibility for Covered California or financial help, or for the amount of financial help I get. I also understand this new income amount will replace any income information I gave Covered California before, including proof-of-income documents or past attestations.

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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