Application for Private Health Insurance

APPLY NOW THROUGH COVERED CALIFORNIA™

Your destination for affordable health insurance

See Inside

Covered California is the place where individuals and families can find affordable health insurance.

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 for Private Health Insurance to see what choices you have through Covered California.

➡ You can use this application to find affordable health insurance for anyone in your family, even if you or they already have insurance.

If you think you might qualify for (1) **free or low-cost insurance,** such as Medi-Cal, (2) **low-cost insurance** for pregnant women through the Access for Infants and Mothers (AIM) program, or (3) **help paying for insurance**, you must use a different application, called the "Application for Health Insurance." You can get a paper application or apply online at **CoveredCA.com**.

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.

Call: 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**

COVERED CALIFORNIA

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.
- **We keep your information private and secure, as required by law.** We'll use your information only to help you get 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 are a federally recognized American Indian or Alaska Native who is getting services from the Indian Health Services, tribal health programs, or urban Indian health programs, 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 your application anyway.** We can call you to help you finish your application.
- **Do not send your health insurance plan enrollment payment with this application.** Your plan will send you an invoice for the amount you owe.

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 for 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**.

CCFRM605 (11/13) EN

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: _____

Do you want to apply for premium assistance to help pay for health insurance for yourself or members of the household?

☐ Yes ***If yes,*** you need a different application. Visit **CoveredCA.com** for the application to see what health insurance you qualify for.

☐ No ***If no,*** continue to fill out this application.

Step 2: Tell us about yourself and your family

Complete Step 2 for each person in your family who needs health insurance.
Start with yourself!

- To apply for more than four people on this application, **make a copy of pages 4 and 5** 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 Social Security numbers or proof of citizenship or immigration status for those in your family who are not applying for health insurance.
- Even if members of your family have health insurance now, you might find better insurance at lower costs through Covered California.

★ 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.

Step 2 *continued on next page*

¿Preguntas?

Llame a Covered California al **1-800-300-0213** (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 *Tell us about **yourself.***

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

Are you: ☐ Single ☐ Never married ☐ Married ☐ Registered domestic partner ☐ Divorced ☐ Widowed

Are you: ☐ Male ☐ Female | Date of birth *(month / day / year):*

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?

☐ Adoption Taxpayer Identification Number (ATIN) _____

☐ Individual Taxpayer Identification Number (ITIN) _____

☐ Religious exemption ☐ I do not qualify for an SSN

★ We use Social Security numbers (SSNs) to verify citizenship and other information. You must provide an SSN if you (or a family member) want to apply for health insurance.

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**.

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 B on page 15 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

▶ If you would like to choose a health insurance plan now, check here ☐ and fill out Attachment C on pages 16 to 18.

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
☐ Black or African American
☐ American Indian or Alaska Native
☐ Asian Indian
☐ Cambodian
☐ Chinese
☐ Filipino
☐ Hmong
☐ Japanese
☐ Korean
☐ Laotian
☐ Vietnamese
☐ Native Hawaiian
☐ Guamanian or Chamorro
☐ Samoan
☐ Other _____

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 an American Indian or Alaska Native, and fill out Attachment A on page 14.

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**.

Even if this person has insurance now, you might find better coverage at lower costs.
If there are more than four family members *on this application, make a copy of pages 4 and 5 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
Number: ( ) –

Other phone number ☐ Home ☐ Cell ☐ Work
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: ☐ Single ☐ Never married ☐ Married ☐ Registered domestic partner ☐ Divorced ☐ Widowed

Is this person: ☐ Male ☐ Female

Date of birth *(month / day / year):*

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 page 6.

★ 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
☐ This person does not qualify for an SSN

Person 2 *continued on next page*

Step 2: Person 2 *(continued)*

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 B on page 15 for a list. Then write the document information here. In most cases the document ID number will be the 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

▶ If this person would like to choose a health insurance plan now, check here ☐ and fill out Attachment C on pages 16 to 18.

Tell us about this person's race *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 program this person qualifies for.*

What is this person's race? *(optional; check all that apply)*

- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Asian Indian
- ☐ Cambodian
- ☐ Chinese
- ☐ Filipino
- ☐ Hmong
- ☐ Japanese
- ☐ Korean
- ☐ Laotian
- ☐ Vietnamese
- ☐ Native Hawaiian
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Other _____

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 an American Indian or Alaska Native, and fill out Attachment A on page 14.

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**.

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
Number: ( ) –

Other phone number ☐ Home ☐ Cell ☐ Work
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: ☐ Single ☐ Never married ☐ Married ☐ Registered domestic partner ☐ Divorced ☐ Widowed

Is this person: ☐ Male ☐ Female

Date of birth *(month / day / year):*

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 page 8.

★ 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
- ☐ This person does not qualify for an SSN

Person 3 *continued on next page*

Step 2: Person 3 *(continued)*

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 B on page 15 for a list. Then write the document information here. In most cases the document ID number will be the 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

▶ If this person would like to choose a health insurance plan now, check here ☐ and fill out Attachment C on pages 16 to 18.

Tell us about this person's race *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 program this person qualifies for.*

What is this person's race? *(optional; check all that apply)*

- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Asian Indian
- ☐ Cambodian
- ☐ Chinese
- ☐ Filipino
- ☐ Hmong
- ☐ Japanese
- ☐ Korean
- ☐ Laotian
- ☐ Vietnamese
- ☐ Native Hawaiian
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Other _____

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 an American Indian or Alaska Native, and fill out Attachment A on page 14.

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**.

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
Number: ( ) –

Other phone number ☐ Home ☐ Cell ☐ Work
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: ☐ Single ☐ Never married ☐ Married ☐ Registered domestic partner ☐ Divorced ☐ Widowed

Is this person: ☐ Male ☐ Female

Date of birth *(month / day / year):*

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 page 10.

★ 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
- ☐ This person does not qualify for an SSN

Person 4 *continued on next page*

Step 2: Person 4 *(continued)*

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 B on page 15 for a list. Then write the document information here. In most cases the document ID number will be the 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

▶ If this person would like to choose a health insurance plan now, check here ☐ and fill out Attachment C on pages 16 to 18.

Tell us about this person's race *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 program this person qualifies for.*

What is this person's race? *(optional; check all that apply)*

- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Asian Indian
- ☐ Cambodian
- ☐ Chinese
- ☐ Filipino
- ☐ Hmong
- ☐ Japanese
- ☐ Korean
- ☐ Laotian
- ☐ Vietnamese
- ☐ Native Hawaiian
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Other _____

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 an American Indian or Alaska Native, and fill out Attachment A on page 14.

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

You can choose an authorized representative

★ You can choose a trusted friend or organization 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. The personal and medical information you provide on it is private and confidential. Covered California needs 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 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.
- 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

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

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

We must give you this Privacy Statement under California Civil Code § 1798.17. You can see Covered California's Privacy Policy at **CoveredCA.com**.

Step 3 *continued on next page*

¿Preguntas?

Llame a Covered California al **1-800-300-0213** (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

- The information I gave on this application is true as far as I know. I know that I may be subject to a penalty for perjury 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 will keep my information private, as the law requires. For more information, or access to personal information in records maintained by Covered California, I can contact the Privacy Officer at **1-800-300-1506** (TTY: 1-888-889-4500).
- I know that I must tell Covered California 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**.
- 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** or **http://oag.ca.gov/contact/general-comment-question-or-complaint-form**.
- I understand that any changes in my information or information of any member(s) in my 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.
- I understand that I must report changes to Covered California within 30 days of the change because it may affect my eligibility to obtain health insurance through a Covered California health plan.
- I give my permission to Covered California to check other agencies' computer records to verify citizenship, satisfactory immigration status, and other information related only to eligibility to see if I and other people on this application qualify for health insurance.

Your right to appeal:

- If I think Covered California has made a mistake, I can appeal the decision. To *appeal* means to tell someone at Covered California that I think the decision is wrong and ask for a fair hearing on the action.
- I know that I can find out how to appeal, including an expedited appeal, and how to get a legal aid referral or free legal help by calling **1-800-300-1506** (TTY: 1-888-889-4500).
- I know that I must file an appeal within 90 days from the date that the notice is mailed or given to me.
- 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 hearings will be conducted by telephone, video conference, or in person.
- I know that if I need help, someone at Covered California can explain my case to me.
- I know that someone at Covered California can explain the circumstances when my eligibility may be maintained or reinstated pending an appeal decision.
- I know that an appeal decision for me or other members of my household may result in a change in my eligibility or the eligibility of other members of my household. The change in eligibility may result in a redetermination of eligibility for all household members.

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 Social Security Administration. 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.

***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**.

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.
- If I am selecting a health plan by filling out and submitting Attachment C, and if I am determined eligible by Covered California to enroll in the plan I selected in Attachment C:
  - » I understand that by signing here 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 I am mentally competent to sign a contract.

Signature of applicant or authorized representative ▶	Date

Covered California certified individuals

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.

☐ Certified Enrollment Counselor Name:	CEC number
Certified Enrollment Entity Name:	CEE number
☐ Certified Insurance Agent Name:	License number
☐ 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.

¿Preguntas?

Llame a Covered California al **1-800-300-0213** (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 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 who needs health insurance?
- ☐ **Sign** this application on **page 12**? If you chose an authorized representative, also sign page 10.

A few more questions *(optional)*

1. Have you had recent changes in your life that made you want to apply for health insurance?
***If yes**, check all that apply.*

- ☐ Moved to California
- ☐ Gained citizenship or lawful presence
- ☐ Gained dependent (by birth, marriage, or adoption)
- ☐ Loss of Medi-Cal coverage
- ☐ Other _____
- ☐ No longer incarcerated
- ☐ Loss of health insurance
- ☐ Federally recognized American Indian/Alaska Native
- ☐ Loss of premium assistance for health insurance through Covered California

When did this life event occur? *(month / day / year)* _____

2. How did you hear about Covered California?
Check all that apply.

- ☐ Outreach and education program
- ☐ Magazine or newspaper ad
- ☐ News program or story
- ☐ Community organization or event
- ☐ Certified Insurance Agent
- ☐ Certified Enrollment Counselor
- ☐ Social media *(e.g., Facebook, Twitter, etc.)*
- ☐ TV ad
- ☐ Radio ad
- ☐ Online ad
- ☐ Mobile app
- ☐ Internet search
- ☐ Provider or hospital
- ☐ Other _____
- ☐ **CoveredCA.com**
- ☐ Brochure
- ☐ Mailer
- ☐ Billboard
- ☐ Sign in retail store
- ☐ Government office
- ☐ Email
- ☐ Pharmacy
- ☐ Friend or family
- ☐ Employer
- ☐ Church
- ☐ Word of mouth

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**.

Attachment A: For American Indians or Alaska Natives

★ **Complete this if you or a family member is American Indian or Alaska Native.**

American Indians and Alaska Natives can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. Federally recognized American Indians and Alaska Natives may not have to pay out-of-pocket costs (such as copayments) and may get special enrollment periods. Be sure to complete this form and send it in with your application and your proof of American Indian or Alaska Native heritage. You may send a document from a federally recognized Indian tribe that shows you are a member of the tribe or affiliated with the tribe. Documents may include a tribal enrollment card or certificate of degree of Indian blood (CDIB) from the Bureau of Indian Affairs.

If you need to tell us about more than four people who are American Indians or Alaska Natives, **make a copy of this page**, and be sure to send it with your application.

Person 1

First name | Middle name | Last name | Suffix *(examples: Sr., Jr., III, IV)*

Is this person a member of a federally recognized American Indian or Alaska Native tribe? ☐ Yes ☐ No

***If yes,** write the name of the tribe:* _____ *and the state of the tribe:* _____

Person 2

First name | Middle name | Last name | Suffix *(examples: Sr., Jr., III, IV)*

Is this person a member of a federally recognized American Indian or Alaska Native tribe? ☐ Yes ☐ No

***If yes,** write the name of the tribe:* _____ *and the state of the tribe:* _____

Person 3

First name | Middle name | Last name | Suffix *(examples: Sr., Jr., III, IV)*

Is this person a member of a federally recognized American Indian or Alaska Native tribe? ☐ Yes ☐ No

***If yes,** write the name of the tribe:* _____ *and the state of the tribe:* _____

Person 4

First name | Middle name | Last name | Suffix *(examples: Sr., Jr., III, IV)*

Is this person a member of a federally recognized American Indian or Alaska Native tribe? ☐ Yes ☐ No

***If yes,** write the name of the tribe:* _____ *and the state of the tribe:* _____

Attachment B: **Step 2 reference** *Use this list to answer the questions in Step 2.*

Immigration status

If you are in one of the groups below, you may qualify for health insurance. If your immigration status is not listed below, you may still qualify and should still apply.

- Lawful Permanent Resident (LPR, or Greencard holder)
- Lawful Temporary Resident (LTR)
- Asylee
- Refugee
- Cuban/Haitian entrant
- Paroled into the U.S.
- Conditional entrant granted before 1980
- Battered spouse, child, or parent
- Victim of trafficking and his/her spouse, child, sibling, or parent
- Granted withholding of deportation or withholding of removal, under the immigration laws or under the Convention against Torture (CAT)
- Individual with non-immigrant status (includes worker visas, student visas, and citizens of Micronesia, the Marshall Islands, and Palau)
- Temporary Protected Status (TPS) or applicant for Temporary Protected Status (TPS)
- Deferred Enforced Departure (DED)
- Deferred action status *Note: If you are an individual with deferred action status under the Department of Homeland Security's deferred action for childhood arrivals in process (DACA), you are not considered to be lawfully present.*
- Applicant for special immigrant juvenile status
- Applicant for adjustment to LPR status, with approved visa petition
- Applicant for asylum
- Applicant for withholding of deportation or withholding of removal, under the immigration laws or under the Convention against Torture (CAT)
- Registry applicants with Employment Authorization Document (EAD)
- Order of supervision (with EAD)
- Applicant for cancellation of removal or suspension of deportation (with EAD)

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**.

Attachment C: Choose your Covered California health insurance plan

★ If you need to tell us about more than four people, **make a copy of this page and the next page** and use them to give us the information. Be sure to send the pages with your application.

To choose your private health insurance plan, write the name or metal tier of the plan you want below. Once you choose a plan, you will need to make your first premium payment for your health care coverage to take effect. **You must make payments directly to the insurance carrier you choose. You may contact them directly or wait for them to send you a bill. Do not mail your payments to Covered California.** *See Frequently Asked Question #8 on page 20 for more information about how to make your first premium payment.*

To learn more about available health plans or premium payment information, visit **CoveredCA.com** or call **1-800-300-1506** (TTY: 1-888-889-4500).

Name *First, middle, last, suffix (for example, Jr., Sr., III, IV)*	**Health plan name**	**Metal tier**	**Metal number**	**Plan type**
Person 1:		☐ Platinum ☐ Gold ☐ Silver ☐ Bronze ☐ Minimum coverage plan		☐ EPO ☐ HMO ☐ HSA ☐ PPO
Person 2:		☐ Platinum ☐ Gold ☐ Silver ☐ Bronze ☐ Minimum coverage plan		☐ EPO ☐ HMO ☐ HSA ☐ PPO
Person 3:		☐ Platinum ☐ Gold ☐ Silver ☐ Bronze ☐ Minimum coverage plan		☐ EPO ☐ HMO ☐ HSA ☐ PPO
Person 4:		☐ Platinum ☐ Gold ☐ Silver ☐ Bronze ☐ Minimum coverage plan		☐ EPO ☐ HMO ☐ HSA ☐ PPO

Plan types
EPO - Exclusive Provider Organization
HMO - Health Maintenance Organization
HSA - Health Savings Account (this plan type allows members to open and contribute to a Health Savings Account)
PPO - Preferred Provider Organization

To complete plan selection, all individuals age 18 or older who are selecting a health plan must agree to and sign the arbitration agreement on the next page.

Attachment C *continued on next page*

Attachment C: Choose your Covered California health insurance plan *(continued)*

Agreement for Binding Arbitration

▶ For each person who selects a Covered California health plan:

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, any contracted health care providers, administrators, or other associated parties, about the membership in the health plan, the coverage for, or the delivery of, services or items, 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, and agree to, the use of binding arbitration to resolve disputes or claims (except for Small Claims Court cases and claims that cannot be subject to binding arbitration under governing law) 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** for my review, or, I can call Covered California at **1-800-300-1506** (TTY: 1-888-889-4500) for more information.

▶ Signatures of enrollees for **all** plans

Signature of **Person 1**, or responsible party, or authorized representative for Person 1, if at least 18 years old ▶	Date
Signature of **Person 2**, or responsible party, or authorized representative for Person 2, if at least 18 years old ▶	Date
Signature of **Person 3**, or responsible party, or authorized representative for Person 3, if at least 18 years old ▶	Date
Signature of **Person 4**, or responsible party, or authorized representative for Person 4, if at least 18 years old ▶	Date

***Attachment C** 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**.

Attachment C: Choose your Covered California pediatric dental plan

For children age 18 or younger only

★ If you would like to apply for pediatric dental services for more than four children, **make a copy of this page.** Use it to give us information, and send it with your application.

If you think you qualify for pediatric dental services for your child and you would like to choose a pediatric dental plan, write the name(s) of the plan(s) below. To learn more about pediatric dental plans provided by Covered California, visit **CoveredCA.com** or call **1-800-300-1506** (TTY: 1-888-889-4500).

Name *First, middle, last, suffix (for example, Jr., Sr., III, IV)*	**Pediatric dental plan name**	**Coverage level**	**Plan type**
Child 1:		☐ High ☐ Low	☐ DEPO ☐ DHMO ☐ DPPO
Child 2:		☐ High ☐ Low	☐ DEPO ☐ DHMO ☐ DPPO
Child 3:		☐ High ☐ Low	☐ DEPO ☐ DHMO ☐ DPPO
Child 4:		☐ High ☐ Low	☐ DEPO ☐ DHMO ☐ DPPO

Plan types
DEPO - Dental Exclusive Provider Organization
DHMO - Dental Health Maintenance Organization
DPPO - Dental Preferred Provider Organization

¿Preguntas?

Llame a Covered California al **1-800-300-0213** (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**.

Frequently Asked Questions

Getting help through Covered California

1. What is Covered California?

Covered California is a new marketplace where individuals and families can get affordable health insurance and is your destination for high-quality health coverage.

Our goal is to make it simple and affordable for Californians to get health insurance. Covered California is a partnership of the California Health Benefit Exchange and the California Department of Health Care Services.

2. How can Covered California help me?

Covered California can help you choose a private insurance plan that meets your health needs and budget.

We can explain the costs and benefits of health insurance plans clearly, so you can compare the different choices available to you. You will know exactly what you're getting and how much you have to pay before you choose your plan.

3. What health insurance is offered through Covered California?

You will have a wide variety of health plans to choose from through Covered California. Health insurance companies **cannot refuse to cover you** because you have been sick before or could not get coverage.

Covered California offers four groups of health insurance plans: platinum, gold, silver, and bronze, plus a minimum coverage plan. Each offers a different level of coverage, from high to low. Health insurance plans that cover more of your medical expenses will usually have a higher premium but allow you to pay less when you receive medical care.

Platinum plans have the highest premium, but they pay roughly 90% of your health care expenses. Gold plans pay roughly 80%, and silver plans pay roughly 70% of your health care expenses. Bronze plans have the lowest premium but pay roughly 60% of covered health expenses. To learn more about the full benefit packages available, please visit **CoveredCA.com** and review the plan documents, such as the plan's Evidence of Coverage, or the plan's insurance policy. Or call us at **1-800-300-1506** (TTY: 1-888-889-4500).

4. Can I get health insurance through Covered California?

Any Californian can get health insurance through Covered California if he or she is a state resident and meets other requirements.

Applicants may qualify for a free or low-cost health plan, or for financial assistance that can lower the cost of premiums and copayments. The amount of financial assistance is based on household size and family income.

To apply for financial assistance, you will need to complete a different application. Visit **CoveredCA.com** or call **1-800-300-1506** (TTY: 1-888-889-4500).

5. Can I get health insurance even if my income is too high?

Yes. Any Californian who qualifies can purchase health insurance regardless of their income.

6. How do I apply?

You can apply for health insurance through Covered California in the following ways:

Online: Visit **CoveredCA.com**. We provide information about each health insurance plan, explained in clear and simple terms.

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

By fax: Fax your application to **1-888-329-3700**.

By mail: Mail the Covered California application to:

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

In person: We have trained Enrollment Counselors or Certified Insurance Agents who can help you. Or you can visit your county social services office. This help is free! For a list of places near where you live or work, visit **CoveredCA.com** or call **1-800-300-1506** (TTY: 1-888-889-4500).

7. How much does it cost?

The cost depends on what health insurance plan you choose. You can use the cost calculator at **CoveredCA.com** to find the cost.

Frequently Asked Questions *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**.

CCFRM605 (11/13) EN

Getting help through Covered California *(continued)*

8. Should I send my first premium payment with this application?

No, do not send your first premium payment to Covered California. You must pay the insurance carrier directly. You can pay your first premium by mail or your insurance carrier may take payment by phone or online. Call them for more information about how you can pay.

If you get a bill from your insurance carrier, please follow the instructions on the invoice to pay it. **Pediatric dental plans are billed separately and require separate payment.**

If you haven't received a bill, call your insurance carrier. It can take up to 36 hours for them to get your information after you apply. For more information about paying your first premium payment, visit **CoveredCA.com** and click the "How to pay" button or call **1-800-300-1506** (TTY: 1-888-889-4500).

9. What if I already have health insurance?

If you already have affordable health insurance from your employer, you do not need to do anything. But you can still apply anyway to find out if you or your family members qualify for more affordable health insurance through Covered California.

10. I don't have all the information I need to answer the questions on the application. What should I do?

If you don't have all the information, sign and submit your application anyway. We will call you to tell you what to do within 10 to 15 calendar days after we get your application. If you don't hear from us, please call us at **1-800-300-1506** (TTY: 1-888-889-4500).

11. Can I get help with my application or with choosing a plan?

Yes! Help is free. Certified Enrollment Counselors and Certified Insurance Agents are available in communities across the state to give you information about new health insurance choices and help you apply. You can also get help by visiting your county social services office. You can get help in many different languages.

Get help with your application or with choosing a plan:

Online: Visit **CoveredCA.com**. We provide information about each health insurance plan, explained in clear and simple terms.

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

In person: We have trained Certified Enrollment Counselors and Certified Insurance Agents who can help you. Or you can visit your county social services office. This help is free! For a list of places near where you live or work, visit **CoveredCA.com** or call **1-800-300-1506** (TTY: 1-888-889-4500).

12. How can I choose a health insurance plan?

You can visit **CoveredCA.com** to shop and compare health insurance plans easily by using the online shop and compare tool.

You can choose the level of coverage that best meets your health needs and budget.

- You can choose to pay a higher monthly cost (called a premium) so that you pay less out of pocket when you need medical care.
- Or you can choose to pay a lower monthly cost, but pay more out of pocket when you need care.

Frequently Asked Questions *continued on next page*

¿Preguntas?

Llame a Covered California al **1-800-300-0213** (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**.

Getting help through Covered California *(continued)*

13. Do I need to have health insurance now that health reform has started?

Starting in January 2014, most people, including children, will be required to have health insurance or pay a tax penalty. A parent or tax filer who claims a child as a tax dependent on his or her federal income tax return will be liable for the dependent child's lack of health coverage, but the tax penalty for an uninsured child under age 18 will be half of the tax penalty for an uninsured adult. Coverage may include insurance through your job, coverage you buy on your own, Medicare, or full-scope Medi-Cal.

Some people are exempt from having health insurance. Those people include, but are not limited to, people whose religious beliefs are opposed to accepting benefits from a health insurance plan, people who are incarcerated after judgment, people who are members of a federally recognized American Indian or Alaska Native tribe, and those people who have to pay more than 8% of their income for health insurance after taking into account any employer contributions.

In 2014, the penalty will be 1% of your yearly income or $95, whichever is higher. The penalty will go up each year. By 2016, the penalty will be 2.5% of your yearly income or $695, whichever is higher. After 2016, the tax penalty will increase each year based on a cost-of-living adjustment.

For more information about penalties, visit **CoveredCA.com**.

14. What if my income changes after I apply?

If your income changes, it may change what kind of health insurance you qualify for.

If you have private health insurance through Covered California, call us to see if you qualify for financial assistance through Covered California. This can lower the cost of your premiums and copayments.

15. Will I be able to use my new Covered California health insurance plan right away?

If you apply for health insurance in October through December 2013, services start as early as January 2014. If you apply in January 2014 or after, services may be able to start the beginning of the following month.

16. What will happen after I apply?

If you apply online or by telephone, you will receive information about whether or not you and your family qualify for Covered California. If you submit a paper application or fax your application in, we will send you a letter within 10 calendar days upon receipt. If you don't hear from us, please call us at **1-800-300-1506** (TTY: 1-888-889-4500).

Other questions

17. Does everyone on the application have to be a U.S. citizen or U.S. national?

No, if you are just applying on behalf of someone in your family, you do not need to send proof of your citizenship or immigration status. However, anyone for whom insurance is being purchased through Covered California must be a legal resident and must have proof of citizenship or immigration status.

18. This application asks for a lot of personal information. Will Covered California share my personal and financial information?

No. The information you provide is private and secure as required by federal and state law. We use your information only to see if you qualify for health insurance.

19. I have a pre-existing condition or disability. Can I get health insurance through Covered California?

Yes, you can get health insurance regardless of any current or past health conditions or disability.

Starting in 2014, most health insurance plans can't refuse to cover you or charge you more just because you have a pre-existing health condition or disability.

Frequently Asked Questions *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**.

CCFRM605 (11/13) EN

Other questions *(continued)*

20. What if I have Medicare?

By law, Medicare members cannot purchase duplicate coverage through an Exchange. So, if you have Medicare, health insurance through Covered California is not appropriate for you. If you are seeking supplemental coverage for your Medicare and do not have retiree coverage, please visit **www.medicare.gov** to learn about about enrolling in a Medicare Advantage plan or purchasing a Medi-gap policy.

21. I just found out I am pregnant. Can I apply for health insurance that will cover me during my pregnancy?

Yes. You can apply for health insurance that can cover prenatal care, labor and delivery, and postpartum care. Health insurance plans can no longer deny you health insurance if you are pregnant.

22. Will I qualify for health insurance if I am not a citizen or do not have satisfactory immigration status?

Anyone who lives in California can apply for health insurance using this application. Only people who are applying must provide Social Security numbers or information about immigration status.

But you may qualify for certain health insurance programs regardless of your immigration status and even if you do not have a Social Security number.

We keep your information private and only share information with other government agencies to see which programs you qualify for.

23. Where can I get information about becoming registered to vote?

If you are not registered to vote where you live now and would like to apply to register to vote today, please visit **registertovote.ca.gov**. Or, call **1-800-345-VOTE (8683)**.

24. I am an American Indian or an Alaska Native. How can Covered California help me?

American Indians or Alaska Natives can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. If you are a federally recognized American Indian or Alaska Native, you may also be eligible for:

- No out-of-pocket costs like deductibles, copayments, and coinsurance (excluding premiums)
- Special monthly enrollment periods

Be sure to complete Attachment A and send it with your proof of American Indian or Alaska Native heritage document. Documents you may use to provide proof of your Native American Indian or Native Alaskan heritage include, but are not limited to:

1. Tribal enrollment card
2. Certificate of degree of Indian blood (CDIB) from the Bureau of Indian Affairs

If you are interested in receiving any of the following benefits, visit **CoveredCA.com** and use the "Application for Health Insurance" to apply and find out if you qualify for:

- Free or low-cost health insurance, such as Medi-Cal
- Low-cost insurance for pregnant women through Access for Infants and Mothers (AIM)
- Assistance paying for private health insurance through Covered California

25. What if I don't agree with the decision Covered California makes?

You can file an appeal. To appeal a decision you don't agree with, contact Covered California in one of these ways:

- **Online:** Visit **CoveredCA.com**.
- **By phone:** Call Covered California at **1-800-300-1506** (TTY: 1-888-889-4500). You can call Monday through Friday, 8 a.m. to 6 p.m., and Saturday, 8 a.m. to 5 p.m. The call is free!
- **By fax:** Fax the appeal to **1-888-329-3700**.
- **By mail:** Mail the appeal to:
  Covered California – Appeals
  P.O. Box 989725
  West Sacramento, CA 95798-9725
- **In person:** We have trained Certified Enrollment Counselors and Certified Insurance Agents who can help you. This help is free!
- For a list of Certified Enrollment Counselors and Certified Insurance Agents near where you live or work, visit **CoveredCA.com** or call **1-800-300-1506** (TTY: 1-888-889-4500).

¿Preguntas?

Llame a Covered California al **1-800-300-0213** (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**.

CCFRM605 (11/13) EN

Getting help in other languages

You can get help with this application in other languages. Call 1-800-300-1506.

Podemos ayudarle en español a llenar esta solicitud. Llame al 1-800-300-0213.

SPANISH

您可以透過其他語言
獲得此申請的幫助。
請致電 1-800-300-1533.

TRADITIONAL CHINESE

Quý vị có thể được trợ giúp về đơn đăng ký này bằng tiếng Việt. Hãy gọi 1-800-652-9528.

VIETNAMESE

이 응용 프로그램에 대한 한국어 지원을 받으실 수 있습니다.
전화: 1-800-738-9116.

KOREAN

Maaari kang kumuha ng tulong para sa aplikasyong ito sa Tagalog. Tumawag sa 1-800-983-8816.

TAGALOG

Koj txais tau kev pab nrog kev tso npe no ua lus Hmoob. Hu 1-800-771-2156.

HMONG

Вы можете получить помощь в оформлении этой заявки на русском языке. Звоните по телефону 1-800-778-7695.

RUSSIAN

Դուք կարող եք հայերենով օգնություն ստանալ այս դիմումի ձևը լրացնելու հարցում: Զանգահարեք 1-800-996-1009.

ARMENIAN

می توانید در ارتباط با این فرم تقاضا به زبان های دیگر کمک دریافت کنید. با شماره 1-800-921-8879 تماس بگیرید.

FARSI

អ្នកអាចទទួលបានជំនួយចំពោះ
ពាក្យសុំនេះជាភាសាខ្មែរ។
សូមទូរស័ព្ទមកលេខ 1-800-906-8528.

KHMER

يمكنك الحصول على المساعدة
بشأن هذا الطلب باللغة العربية.
اتصل بـ 1-800-826-6317.

ARABIC

"Like" Covered California on Facebook!
Go to: Facebook.com/CoveredCA

Follow us! @CoveredCA