Please return this form, completed and signed, before **November 30th** in order to give me ample time to review your plan options.

Leslie A. Williams
INSURANCE SERVICES

2023 Covered California Renewal Form

Name: _____ Date: _____

Address: _____

Email: _____ Phone: _____

Your rates and plan options will be sent to you via email. Appointments are not required as apps are done electronically.

SECTION 1: TAX HOUSEHOLD MEMBERS

A. List the names, dates of birth & social security numbers of **all tax household members**, ***including yourself*** (those who are listed on your taxes), ***even if*** they are not enrolled. Please choose yes or no to each question below.

(Use additional paper if needed.)

1. Name _____ DOB _____ SS _____
   - Are you renewing your Covered California? - _____
   - Are you eligible for Medicare? - _____
   - Are you pregnant? - _____
   - Are you a US Citizen? - _____
   - Are you a member of a federally recognized tribe? - _____
   - Have you served in the military? - _____
   - Have you been offered insurance by your employer? - _____
   - Have you been offered insurance by a spouse's employer? - _____
   - Do you currently have other insurance? - _____

2. Name _____ DOB _____ SS _____
   - Are you renewing your Covered California? - _____
   - Are you eligible for Medicare? - _____
   - Are you pregnant? - _____
   - Are you a US Citizen? - _____
   - Are you a member of a federally recognized tribe? - _____
   - Have you served in the military? - _____
   - Have you been offered insurance by your employer? - _____
   - Have you been offered insurance by a spouse's employer? - _____
   - Do you currently have other insurance? - _____

3. Name _____ DOB _____ SS _____
   - Are you renewing your Covered California? - _____
   - Are you eligible for Medicare? - _____
   - Are you pregnant? - _____
   - Are you a US Citizen? - _____
   - Are you a member of a federally recognized tribe? - _____
   - Have you served in the military? - _____
   - Have you been offered insurance by your employer? - _____
   - Have you been offered insurance by a spouse's employer? - _____
   - Do you currently have other insurance? - _____

4. Name _____ DOB _____ SS _____
   - Are you renewing your Covered California? - _____
   - Are you eligible for Medicare? - _____
   - Are you pregnant? - _____
   - Are you a US Citizen? - _____
   - Are you a member of a federally recognized tribe? - _____
   - Have you served in the military? - _____
   - Have you been offered insurance by your employer? - _____
   - Have you been offered insurance by a spouse's employer? - _____
   - Do you currently have other insurance? - _____

B. List all those expected to file taxes in your tax household ***and*** their filing status (single, married filing jointly, etc).

Name: _____ Status: _____ Name: _____ Status: _____

Name: _____ Status: _____ Name: _____ Status: _____

SECTION 2: TAX HOUSEHOLD INCOME

A. What do you expect your ***total tax household income*** to be for the 2023 tax year? _____

(see reverse side)

B. Please indicate how much ***each member of the tax household*** is expecting to bring in and the source (***employer name***, investment, rental income, pension, social security, etc).

Name: _____ Source: _____ Estimated yearly amount: _____

Name: _____ Source: _____ Estimated yearly amount: _____

Name: _____ Source: _____ Estimated yearly amount: _____

Name: _____ Source: _____ Estimated yearly amount: _____

C. Are there any deductions or other taxable income you need to report? Please list the source and amount below.

_____

_____

SECTION 3: OTHER

I understand I am responsible for reporting any changes to Covered California within 30 days. I agree and certify under the penalty of perjury that I have read the reporting requirements in this section.

Do you agree to report any changes to the information in your Covered California application directly to Covered California or to our office within 30 days? _____

Do you give Covered California consent to verify your information for up to 5 years? *(Covered California must have consent to verify your information in order for you to be provided a subsidy.)* _____

Please read this information about your application and type or sign your full name below.

- You can apply for free or low-cost health care through Medi-Cal at any time of the year. To enroll in a health plan through Covered California outside of Open Enrollment, you must have a qualifying life event that creates a Special Enrollment Period. Please make sure your application is true and correct. If you provide false information, your coverage may be canceled. The U.S. Department of Health and Human Services may also fine you for providing false information.

- You may be fined up to $25,000 if you negligently or with intentional disregard for the rules provide false information on your application. You may be fined up to $250,000 if you knowingly lie on your application. Covered California may request that you provide documents to show you qualify for coverage.

I certify (or declare) under the penalty of perjury under the laws of the State of California that the foregoing is true and correct.

- I have understood all the questions on this application and provided true and correct answers to such questions to the best of my knowledge. Where I do not have personal knowledge of an answer, I have made every reasonable attempt to verify (or confirm) the information with someone who has personal knowledge of the answer. I understand I am responsible for the information I provide.

- I know that if I am not truthful there may be civil/and or criminal penalty for perjury. I know that all of information disclosed on this application will be used to determine eligibility of every person applying for health insurance on this application. This information will be kept private as required by federal and California Law.

- I understand that if I have received federal advanced premium tax credits for health coverage through Covered California during the previous benefit year, I must have filled or will file a federal tax return for that year.

_____ _____

Covered California Primary Applicant Signature (typing your name is your signature) *Date*

Please return via: Website Upload- www.lawilliamsinsurance.com/2023coca ~ Email- jennifer@lawilliamsinsurance.com ~
Mail- 2295 Hilltop Drive,
Suite 5, Redding, CA 96002
Fax- 530-222-8231