



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

Name: _____ Date: _____

Address: _____

Email: _____ Phone: _____

SECTION 1: TAX HOUSEHOLD MEMBERS

(Use additional paper if needed.)

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.

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

If yes & we did not enroll you, please call Covered California @ 800-300-1506 & ask them to assign Leslie Williams in Redding, CA as your agent. You will need to do this before submitting this form.

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

If yes & we did not enroll you, please call Covered California @ 800-300-1506 & ask them to assign Leslie Williams in Redding, CA as your agent. You will need to do this before submitting this form.

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

If yes & we did not enroll you, please call Covered California @ 800-300-1506 & ask them to assign Leslie Williams in Redding, CA as your agent. You will need to do this before submitting this form.

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

If yes & we did not enroll you, please call Covered California @ 800-300-1506 & ask them to assign Leslie Williams in Redding, CA as your agent. You will need to do this before submitting this form.

B. List all those expected to file taxes in your tax household and their filing status (single, married filing jointly, etc). Note: If you are married, Covered California requires you to file taxes "Married Filing Jointly" in order to qualify.

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 2024 tax year? _____

This figure should match the total of the figures in Section B on the next page. (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). ***The total of these figures should match the total in Section A.***

Name: _____ Source: _____ Estimated yearly amount: _____

Name: _____ Source: _____ Estimated yearly amount: _____

Name: _____ Source: _____ Estimated yearly amount: _____

Name: _____ Source: _____ Estimated yearly amount: _____

Household Total Amount: _____

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

SECTION 3: AUTHORIZATION

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.) Answer _____

Please read this information about your application and type or sign your full name below. TYPING YOUR NAME IS CONSIDERED A DIGITAL SIGNATURE WHEN ACCOMPANIED BY A FORM OF SECURITY, WHICH IS YOUR MOTHER'S MAIDEN NAME.

- 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.

Applicant Signature

Mother's Maiden Name

Date