STATE OF CALIFORNIA
CALIFORNIA HEALTH BENEFIT EXCHANGE/COVERED CALIFORNIA (Exchange/CC)

NOTIFICATION OF DECEASED – BY ENROLLED MEMBER
HBEX 411b (04/18)

Notification of Deceased by an Enrolled Member

Please complete this form if you are listed on the account and wish to report the death of the Primary Account Holder or another enrollee listed on the account. Please note that the submission of this form will result in a redetermination of eligibility for any remaining account members. If the deceased was listed as the Primary Account Holder, he or she will continue to be listed as the Primary Account Holder throughout the remaining enrollment period; however, your premiums will be adjusted accordingly. Please allow 30 days for processing. The form maybe be mailed or faxed to the following.

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

Fax: (888) 329-3700

Deceased Consumer's Information *(As indicated on the Covered California Account)*		
Last Name:	First Name:	Middle Initial:
Address:	City/State:	Zip Code:
Covered California Case or Account Number:	Date of Birth:	Date of Death:

Reporting Member's Information *It is very important to provide your current contact information. Covered California will need to contact you regarding the updates made to the account.*		
Last Name:	First Name:	Middle Initial:
Address:	City/State:	Zip Code:
Daytime Phone Number *(Required)*	Email Address:	

What is your relationship to the deceased?		
Do you need a copy of the previous year's IRS form 1095A	Yes ☐	No ☐
Does the address on the account need to be updated?	Yes ☐	No ☐
What is the new address?	City/State:	Zip Code:

Attached Copy of Reporting Member's Identifying Information. *(If no identifying document is attached, your signature must be notarized.)*	
California Driver's License ☐	California Identification Card ☐
Federal Issued Identification Card ☐	Notary ☐
Date Notarized:	UNOFFICIAL UNLESS STAMPED BY NOTARY PUBLIC
Notarized By:	
Notary Public Number:	

Reporting Member's Signature	
I understand Covered California may not be able to comply with my request but will provide me with a response. I declare under penalty of perjury that the information on this form is true and correct.	
Signature:	Date:

The information requested on this form is required by the California Health Benefit Exchange to process your request and will be used solely for this purpose. Failure to provide this information may result in the denial of your request. Legal references authorizing the collection or maintenance of the information provided on this form include Sections 1798.22, 1798.25, 1798.27 and 1798.35 of the California Civil Code and Section 155.260(a) of the Code of Federal Regulations. California Health Benefit Exchange, Privacy Office, 1601 Exposition Blvd, Sacramento, CA 95815 (800) 889-3871.