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

REQUEST TO AMEND PERSONAL INFORMATION
HBEX 409 (8/15)

Request to Amend Personal Information

You have the right to request amendments to the records Covered California creates or maintains about you. We will act upon your request within 30 days of our receipt of your request. If your request is denied, we will let you know the reasons for the denial in writing. Should we deny your request, you have the right to request a review of our decision and we will provide you the name and contact information of the reviewing official in conjunction with a written copy of our decision. Please complete this form and attach all relevant documents. You may submit the form and documents by either mail or fax.

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

Fax: (888) 329-3700

Consumer Information *(As indicated on your Covered California Account)*		
Last Name:	First Name:	Middle Initial:
Address:	City/State:	Zip Code:
Covered California Case or Account Number:		Date of Birth:
Daytime Phone Number:	Email Address	

What personal information do you want to amend? Why do you want it amended?

What should the record state?

Address Verification *(Please attached a copy of one of the following with your name and current address.)*		
California Driver's License ☐	Utility Bill ☐	Other ☐

Identity Verification *(Please attached a copy of one of the following. If no identifying document is attached, your signature must be notarized.)*	
California Driver's License ☐	State of California Identification Card ☐
Federal Issued I.D. Card ☐	Notary ☐
Date Notarized:	UNOFFICIAL UNLESS STAMPED BY NOTARY PUBLIC
Notarized By:	
Notary Public Number:	

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 Benefits Exchange, Privacy Office in order to process your request. The information you provide on this form is required to process your request and will be used by the Privacy Office for that 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 Benefits Exchange, Privacy Office, 1601 Exposition Blvd, Sacramento, CA 95815 (800) 889-3871.	