STATE OF CALIFORNIA
CALIFORNIA HEALTH BENEFIT EXCHANGE/COVERED CALIFORNIA (Exchange/CC)
NOTIFICATION OF DECEASED
HBEX 411a (12/15)

Courtesy Notification of Deceased

Please complete this form to provide Covered California with a courtesy notification for the deceased enrollee. This change in household size will result in a termination of coverage (if the deceased was the sole enrollee) or a redetermination of eligibility for remaining enrollees. 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:

Reporting Individual		
Last Name:	First Name:	Middle Initial:
Address:	City/State:	Zip Code:
Daytime Phone Number *(Required)*	Email Address:	

Please include a copy of the following document:

1. **Death Certificate -** *An original is not required*

Are there any additional notes Covered California should add to the individuals account?

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.