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

Your destination for affordable health insurance, including Medi-Cal

Case Number: ____________

Attestation of Income, No Documentation Available

Please print using CAPITAL LETTERS only

I, ____________
(first name)

____
(middle name)

____
(last name)

attest that my household's projected annual income for the benefit year in which I will receive financial assistance for my health plan is *(annual income)*

$ ____________

- I understand the information provided on this form will only be used to decide if I qualify for financial help. Covered California will keep this information private, as required by law.
- I understand I must report any income changes to Covered California within 30 days. I understand this may change the amount of financial help I get or the level of cost-sharing I qualify for.
- I understand this income attestation is only good for the benefit year I'm applying for. I understand I will need to renew my income attestation each year.
- I understand if I get more tax credits (financial help) than I qualify for, I may need to payback some or all of the extra amount to the IRS when I file my federal income tax return.
- I declare, under the penalty of perjury under California law, that the information I've givenon this form is true and correct.

☐ ***(optional)*** Covered California may update my application with the income amount I list on this form. I understand this may change my eligibility for Covered California or financial help, or for the amount of financial help I get. I also understand this new income amount will replace any income information I gave Covered California before, including proof-of-income documents or past attestations.

Applicant's Signature: ______________________________ Date: ____________
MM/DD/YYYY

Send your form in one of the following ways:

Electronic Submission
For faster processing upload this document directly to your online account at CoveredCA.com

Fax
(888) 329-3700

Mail
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