



Covered California  
 Special Enrollment Team  
 P.O. Box 13310  
 Sacramento, CA 95813



**COVERED  
 CALIFORNIA**

*Your destination for quality  
 healthcare, including Medi-Cal*

Case Number: \_\_\_\_\_

**Attestation to Lack of Information Form  
 (Termination of Employment or Reduction of Employee Hours)**

I \_\_\_\_\_, cannot obtain a document to  
 (Print your name)

verify my qualifying life event because:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

My coverage was terminated through my employment because:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

My previous health carrier was: \_\_\_\_\_

My last date of coverage was: \_\_\_\_\_

My member number was: \_\_\_\_\_

My group number was: \_\_\_\_\_

I declare under the penalty of perjury, under the laws of the State of California, that what I stated above is true and correct.

Applicant's Signature: \_\_\_\_\_ Today's Date: \_\_\_\_\_

**How do I submit my information?**

You can submit your information in one of three ways:

- **The quickest way to send us your information is online at <http://www.coveredca.com/get-help/contact/>.**
  - Click on the link for "Submitting Documents for Special Enrollment."
  - Click on the link called "Upload your document here."
  - You will be taken to another page where you may upload your SEP Verification documents online.

- **Mail your information to the following address:**

**CA HBEX/Covered California  
Special Enrollment Team  
P.O. Box 13310  
Sacramento, CA 95813**

- **Or fax your information to: 1-888-217-9310.**