Start application here *(use blue or black ink only)*

Step 1: Tell us about the adult who will be our main contact for this application

First name | Middle name | Last name | Suffix *(examples: Sr., Jr., III, IV)*

Home address | Apartment #

City *(home address)* | State | ZIP code | County

☐ Check here if you do not have a home address. You must give us a mailing address below.

☐ Check here if your mailing address is the same as your home address.
If it is not the same, you must give us your mailing address below:

Mailing address or P.O. box *(if different from home address)* | Apartment #

City *(mailing address)* | State | ZIP code | County

Best phone number to reach you ☐ Home ☐ Cell ☐ Work
Number: ( ) –

Other phone number ☐ Home ☐ Cell ☐ Work
Number: ( ) –

What language should we write to you in?

What language do you want us to speak to you in?

How would you like to get information about this application?

☐ Phone ☐ Mail ☐ Email Email address: _____

Are you applying for a child less than 1 year old?

Infants less than one year old are eligible for Medi-Cal if their mother was on Medi-Cal or AIM at the time of delivery. You do not need to fill out an application to get Medi-Cal for an infant born to a mother with Medi-Cal or AIM at the time of delivery. Call your county social services office when your baby is born to make sure your baby is covered. Or fill out the information below.

Optional: If the following information is provided, the infant may be automatically eligible for Medi-Cal. You do not have to fill out Step 2 of this application for the infant.

Are you applying for a child less than 1 year old? ☐ Yes ☐ No

If yes, did the child's mother have Medi-Cal or AIM when the child was born? ☐ Yes ☐ No

If yes, will the child's mother be listed on this application? ☐ Yes ☐ No

If yes, the mother is Person #_____ on this application

If no, what is the mother's first and last name? _____

Please provide the mother's Medi-Cal number, AIM number, or SSN_____

Step 2: Tell us about yourself and your family

Your income and family size help us decide what programs you qualify for. With this information, we can make sure everyone gets the best coverage possible.

You must include these people on this application:

- Your spouse
- Your children who live with you
- All parents living in the home with their child
- Anyone on your federal income tax return, if you file one. You don't need to file taxes to apply for health insurance.

★ If you are claimed as a dependent on someone else's tax return, you must include all members of the tax filing household that claimed you and any family members living with you.

★ Anyone else who lives with you – for example, a boyfriend, girlfriend, or roommate – will need to file his or her **own** application if they want health insurance.

Complete Step 2 for each person in your family. Start with yourself!

- To apply for more than four people on this application, **make a copy of pages 6–8** for each additional person.
- We'll keep all your information private, as required by law. We'll use personal information only to see if you qualify for health insurance. You do not need to provide the immigration status or Social Security number (SSN) for those in your family who are not applying for health insurance.

Person 1 *Tell us about **yourself.***

First name | Middle name | Last name | Suffix *(examples: Sr., Jr., III, IV)* | Relationship to you **Self**

Are you: ☐ Male ☐ Female

Are you: ☐ Single ☐ Never married ☐ Married ☐ Divorced ☐ Registered domestic partner ☐ Widowed

Date of birth *(month / day / year)*

Are you pregnant? ☐ Yes ☐ No ***If yes,*** how many babies are expected? _____

What is the expected delivery date? _____

Applying for health insurance *Even if you have insurance now, you might find better coverage or lower costs.*

▶ Are you applying for health insurance for yourself?

- ☐ **Yes** ***If yes,*** answer the questions below and complete pages 4 and 5.
- ☐ **No** If you are **not** applying for yourself but you are applying for a dependent, be sure to fill in page 5.
- ☐ **No** If you are **not** applying for yourself or for a dependent, go to page 6.

★ Social Security number (SSN)

___ ___ ___ – ___ ___ – ___ ___ ___ ___

If you do not have an SSN, what is the reason?

- ☐ Adoption Taxpayer Identification Number (ATIN) _____
- ☐ Individual Taxpayer Identification Number (ITIN) _____
- ☐ Religious exemption
- ☐ I do not qualify for an SSN

★ You must provide a Social Security number (SSN) if you wish to apply for health insurance. We use Social Security numbers (SSNs) to check income and other information. Even if you are not applying, giving your SSN will help us review your application faster. Be sure to provide your SSN if you are not applying for yourself but you file taxes and are applying for someone in your tax household.

If someone who is applying does not have an SSN and would like help getting one, call **1-800-300-1506** (TTY: 1-888-889-4500) or visit **CoveredCA.com**.

***Person 1** continued on next page*

Need help? Call Covered California at **1-800-300-1506** (TTY: 1-888-889-4500). The call is free. You can call Monday to Friday, 8 a.m. to 8 p.m., and Saturday, 8 a.m. to 6 p.m. Or visit **CoveredCA.com**.

Step 2: Person 1 *(continued)*

Federal income tax information

If you don't file taxes, you can still qualify for free or low-cost insurance through Medi-Cal. We will keep your information private. We will use your information only to decide if you qualify for health insurance.

Are you the primary tax filer (your name was first on the tax return)? ☐ Yes ☐ No

Only one person on this application can be the primary tax filer.

Are you going to file taxes for the **benefit** year?
☐ Yes ☐ No

If yes, how will you file?
☐ Head of household ☐ Single
☐ Married filing jointly ☐ Married filing separately

Does anyone claim you as a dependent on their taxes? ☐ Yes ☐ No

If yes, who?
☐ Person # _____ on this application
☐ This person is a parent without custody
☐ This person is a parent without custody who is not listed on this application

Do you have other health insurance or are you offered insurance through a job? ☐ Yes ☐ No

If yes, fill out Attachment B on pages 22 and 23.

Do you have a physical, mental, emotional, or developmental disability?
☐ Yes ☐ No *See FAQ #27 for more information on what it means to have a disability.*

Do you need help with long-term care or home and community-based services? ☐ Yes ☐ No

Are you a U.S. citizen or U.S. national? ☐ Yes ☐ No

If you are **not** a U.S. citizen or U.S. national, answer these questions:

Do you have satisfactory immigration status? ☐ Yes ***To see if you have satisfactory status,*** *go to Attachment E on page 27 for a list. Then write the document information here. In most cases your document ID number will be your Alien Registration Number.*

Document type: _____ ID number: _____

Country of issuance: _____ Expiration date: _____

Name as it appears on the document: _____

Have you lived in the U.S. since 1996?
☐ Yes ☐ No

Are you, your spouse, or an unmarried dependent child an honorably discharged veteran or active-duty member of the U.S. armed forces? ☐ Yes ☐ No

Do you receive Medicare benefits?
☐ Yes ☐ No

Did you have a medical expense in the last 3 months that you need help paying for?
☐ Yes ☐ No

Do you live with any children under the age of 19? ☐ Yes ☐ No

If yes, do you take care of the child or children? ☐ Yes ☐ No

Are you 18 to 20 years old and a full-time student? ☐ Yes ☐ No

Are you 18 to 26 years old? ☐ Yes ☐ No ***If yes,*** were you in foster care in any state on your 18th birthday? ☐ Yes ☐ No

Are you 18 years old or younger? ☐ Yes ☐ No How many parents live with you? _____

Are you temporarily living out of state? ☐ Yes ☐ No

If you would like to choose a health insurance plan now, check here ☐ and fill out Attachment D on page 25.

Tell us about your race

This information is confidential and will only be used to make sure that everyone has the same access to health care. It will not be used to decide what health insurance you qualify for.

What is your race? *(optional; check all that apply)*

☐ White
☐ Black or African American
☐ American Indian or Alaska Native
☐ Asian Indian
☐ Cambodian
☐ Chinese
☐ Filipino
☐ Hmong
☐ Japanese
☐ Korean
☐ Laotian
☐ Vietnamese
☐ Native Hawaiian
☐ Guamanian or Chamorro
☐ Samoan
☐ Other _____

Are you of Hispanic, Latino, or Spanish origin? *(optional)* ☐ Yes ☐ No

If yes, check which ones:
☐ Mexican, Mexican American, Chicano
☐ Salvadoran ☐ Guatemalan
☐ Cuban ☐ Puerto Rican
☐ Other Hispanic, Latino, or Spanish origin: _____

★ ☐ Check here if you are an American Indian or Alaska Native, and fill out Attachment A on pages 20 and 21.

Person 1 *continued on next page*

Step 2: Person 1 *(continued)*

Tell us about your current job and how you get money *Attach an extra page if you need more space.*

Do you work now? ☐ **Yes** ***If yes,*** answer the questions below. ☐ **No** ***If no,*** go to other income on this page.

Where do you work now? *If you have more jobs, attach another sheet of paper.*

JOB 1:
How do you get paid?

☐ Hourly: How many hours per week?_____ ☐ Daily: How many days per week?_____
☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ Quarterly
☐ Every six months ☐ Yearly ☐ One-time payment *(See FAQ #33 on page 33.)*

Employer name *(optional)*

How much do you get paid (before taxes)? $_____

JOB 2:
How do you get paid?

☐ Hourly: How many hours per week?_____ ☐ Daily: How many days per week?_____
☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ Quarterly
☐ Every six months ☐ Yearly ☐ One-time payment *(See FAQ #33 on page 33.)*

Employer name *(optional)*

How much do you get paid (before taxes)? $_____

Are you self-employed?

JOB 1: Are you self-employed? ☐ **Yes** ***If yes,*** answer the questions below. ☐ **No** ***If no,*** go to other income on this page.

Type of work

How much *net income* will you get from self-employment this month? $_____
Net income means the profits left over after expenses are paid. *Attachment E on page 27 lists what could be counted.*

JOB 2: Are you self-employed? ☐ **Yes** ***If yes,*** answer the questions below. ☐ **No** ***If no,*** go to other income on this page.

Type of work

How much *net income* will you get from self-employment this month? $_____
Net income means the profits left over after expenses are paid. *Attachment E on page 27 lists what could be counted.*

Do you have other income? *Other income is money you get from something other than your job. Do not include child support payments, veteran's payments, or Supplemental Security Income (SSI). Go to Attachment E on page 27 to see examples of other income.*

Do you have other income? ☐ **Yes** ***If yes,*** answer the questions below. ☐ **No** ***If no,*** go to income change on this page.

Where does this income come from?	**How often do you get paid?** *(check one)*	**How much?**
	☐ Hourly: How many hours per week?_____ ☐ Daily: How many days per week?_____ ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Every six months ☐ Yearly ☐ One-time payment *(See FAQ #33 on page 33.)*	$
	☐ Hourly: How many hours per week?_____ ☐ Daily: How many days per week?_____ ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Every six months ☐ Yearly ☐ One-time payment *(See FAQ #33 on page 33.)*	$

Does your income change from month to month? *If it does, answer the two questions below.*

What do you expect your total income to be **this** year? *(optional)* $_____

If you expect your income to change **next** year, what will the new total income be? *(optional)* $_____

Do you have deductions? *If you pay for certain things that can be deducted on a federal income tax return, telling us about them may lower the cost of health insurance. Do not include self-employment expenses. Attachment E on page 27 lists other types of deductions.*

Do you have deductions? ☐ **Yes** ***If yes,*** answer the questions below. ☐ **No** ***If no,*** go to the next page.

Type of deduction	**How often do you get or pay for this deduction?** *(check one)*	**How much?**
☐ Alimony paid ☐ Student loan interest ☐ Other	☐ Hourly: How many hours per week?_____ ☐ Daily: How many days per week?_____ ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Every six months ☐ Yearly ☐ One-time payment *(See FAQ #33 on page 33.)*	$
☐ Alimony paid ☐ Student loan interest ☐ Other	☐ Hourly: How many hours per week?_____ ☐ Daily: How many days per week?_____ ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Every six months ☐ Yearly ☐ One-time payment *(See FAQ #33 on page 33.)*	$

Need help?

Call Covered California at **1-800-300-1506** (TTY: 1-888-889-4500). The call is free. You can call Monday to Friday, 8 a.m. to 8 p.m., and Saturday, 8 a.m. to 6 p.m. Or visit **CoveredCA.com**.

Step 3: Please read and sign this application

You can choose an authorized representative

★ You can choose someone to be your "authorized representative." An authorized representative is a person you allow to see your application and talk with us about it now and in the future.

Name of authorized representative

Address | Apartment #

City	State	ZIP code	County

By signing, you allow this person to sign your application, to get official information about this application, and to act for you on all future matters with this agency.

Your signature ▶	Date

Privacy statement

This application is for health insurance through Covered California or for benefits through the Department of Health Care Services (DHCS). The personal and medical information you provide on it is private and confidential. Covered California or the DHCS needs it to identify you and the other people on this application and to administer our programs.

We will share your information with other state, federal, and local agencies, contractors, health plans, and programs only to enroll you in a plan or program or to administer programs, and with other state and federal agencies as required by law.

- You must answer all of the questions on this application unless they are marked "optional." If your application is missing anything that we require, we will contact you to get it. ➡ ***If you do not provide it,*** we will not be able to make a decision on your application. You may have to submit a new application, or you may not be able to get health insurance through Covered California, or your application for benefits may be denied.
- In most cases, you have the right to see personal information about you that is in federal and state records. You can see it in an alternative format (such as large print) if you need that.

For more information or to see **Covered California** records, contact the Privacy Officer at:

Covered California
Attn: Privacy Officer
P.O. Box 989725
West Sacramento, CA 95798-9725

Phone: 1-800-300-1506
TTY: 1-888-889-4500

For the **Department of Health Care Services**, contact the Information Protection Unit at:

P.O. Box 997413, MS 4721
Sacramento, CA
95899-7413

Phone: 1-866-866-0602
TTY: 1-877-735-2929

These state and federal laws give us the right to collect and keep the information on the application:

Covered CA: 42 U.S.C. § 18031; CA Government Code §§ 100502(k) and 100503(a)

DHCS: CA Welfare and Institutions. Code § 14011 and Article 3, Chapters 5 and 7, Parts 2 and 3, Division 9

We must give you this Privacy Statement under CA Civil Code § 1798.17. You can see Covered California's Privacy Policy at CoveredCA.com. See DHCS's Notice of Privacy Practices at dhcs.ca.gov.

Step 3 *continued on next page* ⏭

Need help? Call Covered California at **1-800-300-1506** (TTY: 1-888-889-4500). The call is free. You can call Monday to Friday, 8 a.m. to 8 p.m., and Saturday, 8 a.m. to 6 p.m. Or visit **CoveredCA.com**.

Step 3: Please read and sign this application *(continued)*

Your rights and responsibilities *(continued)*

Your right to appeal:

- If I think Covered California or the Medi-Cal program has made a mistake, I can appeal its decision. To appeal means to tell someone at Covered California or the Medi-Cal program that I think its decision is wrong and ask for a fair review of the action.
- I know that I can find out how to appeal by calling **1-800-300-1506** (TTY: 1-888-889-4500).
- I know that I must file an appeal within 90 days of the decision.
- I know that I can represent myself or have someone else represent me in my appeal, such as an authorized representative, a friend, a relative, or a lawyer.
- I know that if I need help, someone at Covered California, the Medi-Cal program, or the county social services office can explain my case to me.

Renewal of insurance

To make it easier to continue to get health insurance in future years, I agree to allow Covered California to use computer sources, such as the IRS, to check my income. If the sources show I am still eligible, my insurance coverage can be renewed for another 12 months and I won't have to fill out a renewal form or send other paperwork.

I understand that if I choose not to allow Covered California to use computer sources, I must complete a renewal packet every 12 months in order to continue my health insurance.

I agree to allow Covered California or the Medi-Cal program to check my information for:

☐ 5 years ☐ 4 years ☐ 3 years ☐ 2 years ☐ 1 year

OR

☐ I do not want Covered California to check my tax returns at renewal.

Declaration and signature *This is required.*

I declare under penalty of perjury that what I say below is true and correct.

- I understood all questions on this application and gave true and correct answers as far as I know. Where I did not know the answer myself, I made every reasonable attempt to confirm the answer with someone who did know.
- I know that if I do not tell the truth on this application, there may be a civil or criminal penalty for perjury that may include up to four years in jail. (See California Penal Code Section 126.)
- I know that the information in this application will be used to decide if the people who are applying qualify for health insurance. Covered California will keep the information private, as required by federal and California law.
- I agree to notify Covered California by calling **1-800-300-1506** (TTY: 1-888-889-4500) or visiting **CoveredCA.com** if anything changes on this application for any person applying for health insurance.
- If I am selecting a health plan by filling out and submitting Attachment D, and if I am determined eligible by Covered California to enroll in the plan I selected in Attachment D:
  - I understand that by signing here I am entering into a contract with the issuer of that plan.
  - I am at least 18 years of age or I am an emancipated minor, and I am mentally competent to sign a contract.

Signature of applicant or authorized representative ▶	Date

***Step 3** continued on next page*

Need help? Call Covered California at **1-800-300-1506** (TTY: 1-888-889-4500). The call is free. You can call Monday to Friday, 8 a.m. to 8 p.m., and Saturday, 8 a.m. to 6 p.m. Or visit **CoveredCA.com**.

Step 3: Please read and sign this application *(continued)*

Complete this section if you are a Covered California certified individual helping someone fill out this application.

I certify that as a Certified Enrollment Counselor, Certified Insurance Agent, or Certified Plan-Based Enroller, I helped the applicant complete this application and that this service was free of charge. I also certify that I gave true and correct answers to all questions on this application as far as I know. I explained to the applicant, in easy-to-understand language, the risk to the applicant of providing inaccurate information, and the applicant understood the explanation.

☐ Certified Enrollment Counselor Name:	CEC number
Certified Enrollment Entity Name:	CEE number
☐ Certified Insurance Agent Name:	License number
☐ Certified Plan-Based Enroller Plan:_____ Name:	Certification number
Certified individual's signature ▶	Date

The state will not compensate the Covered California Certified Enrollment Entity unless the Certified Enrollment Counselor fills out this section completely and correctly when the application is submitted.

Step 4: Mailing information and checklist

Mail your signed application to:

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

Did you remember to:

- Tell us about everyone in your family and household, even if they don't need insurance? See page 3 for the list of whom to include.
- Ask your employer about any job-related insurance you may qualify for?
- **Sign** this application on **page 17**? If you chose an authorized representative, also sign page 15.

A few more questions *(optional)*

1. **Would you like to be considered for all Medi-Cal programs?** ☐ Yes ☐ No
   There are other Medi-Cal programs for people 65 years old or older, people with a disability, or people with special health care needs.

   If you check yes, we will contact you to get information about your property and assets.

2. **Have you had any recent changes in your life that made you want to apply for health insurance?**
   If yes, check all that apply.

   ☐ Moved to California
   ☐ Gained citizenship or lawful presence
   ☐ Loss of health insurance
   ☐ Gained dependent (by birth, marriage, or adoption)
   ☐ Other
   ☐ No longer incarcerated
   ☐ Newly eligible for premium assistance
   ☐ Applying for Medi-Cal
   ☐ American Indian or Alaska Native

   When did this life event occur? *(month / day / year)* _____

***Step 4** continued on next page*

Attachment B: Tell us about your family's health insurance

★ If you need to tell us about more than four people who have other health insurance, **make a copy of this page**, and be sure to send it with your application.

Tell us about the health insurance you have now

Answer these questions for everyone who needs help paying for health insurance.

We need to know if anyone applying for health insurance has coverage now. You do not have to tell us about coverage that is not considered minimum essential coverage. Examples of the types of plans you don't have to tell us about are: Indian Health Service, tribal health program, urban Indian health program, flex savings plans, health savings accounts, or insurance available in another country.

We do need to know if anyone has any of the following health insurances now: COBRA, employer-sponsored insurance, Peace Corps, retiree health plan, TRICARE/CHAMPUS, veterans health program, or other health insurance. Does anyone have any of these insurances?

☐ **Yes** ***If yes,*** fill in this page. If you need more space, attach another sheet of paper.
☐ **No** ***If no,*** go to page 23.

Note: If you have private health insurance you bought on your own, check the box for "Other health insurance" under "What type?" in the table below.

Name *First, middle, last, suffix (for example, Jr., Sr., III, IV)*	**What type?** *(choose one)*
Person 1: _____ Has this person been offered affordable full-coverage health insurance for January 2014? ☐ Yes ☐ No	☐ COBRA ☐ Employer-sponsored insurance ☐ Peace Corps ☐ Other health insurance ☐ Veteran's health program ☐ Retiree health plan ☐ TRICARE/CHAMPUS
Person 2: _____ Has this person been offered affordable full-coverage health insurance for January 2014? ☐ Yes ☐ No	☐ COBRA ☐ Employer-sponsored insurance ☐ Peace Corps ☐ Other health insurance ☐ Veteran's health program ☐ Retiree health plan ☐ TRICARE/CHAMPUS
Person 3: _____ Has this person been offered affordable full-coverage health insurance for January 2014? ☐ Yes ☐ No	☐ COBRA ☐ Employer-sponsored insurance ☐ Peace Corps ☐ Other health insurance ☐ Veteran's health program ☐ Retiree health plan ☐ TRICARE/CHAMPUS
Person 4: _____ Has this person been offered affordable full-coverage health insurance for January 2014? ☐ Yes ☐ No	☐ COBRA ☐ Employer-sponsored insurance ☐ Peace Corps ☐ Other health insurance ☐ Veteran's health program ☐ Retiree health plan ☐ TRICARE/CHAMPUS

Attachment B *continued on next page* ⏩

Attachment B: Tell us about your family's health insurance *(cont'd)*

Employer health insurance *Answer these questions for everyone who needs help paying for health insurance.*

★ We need to know about any health insurance you could get through someone's job. You can use Attachment C, Employer Insurance Form, on page 24 to help you complete this section. Answer these questions or use Attachment C **only** if someone in the household qualifies for health insurance from someone's job.

Is anyone on this application offered health insurance by an employer?

*This could be someone else's job, such as a parent's or a spouse's. It could also include COBRA, TRICARE, federal or state employer, private employer, or Peace Corps plans. You may have additional health insurance that you do **not** have to report to us. The following are **examples** of additional coverage (not considered minimum essential coverage) you do not have to tell us about: flex savings plans, health savings accounts, disability insurance, or insurance available in another country.*

☐ **Yes** ***If yes,*** answer these questions. If you need more space, attach another sheet of paper.
☐ **No** ***If no,*** go back to the application to continue.

Name *First, middle, last, suffix (for example, Jr., Sr., III, IV)*	**Employer name** *(optional)*	**This person:**	**How much does this person pay in monthly premiums?**	**Does this health plan meet the *minimum value standard**?**
Person 1:		☐ Is enrolled now ☐ Plans to enroll *Start date* _____ ☐ Is not enrolled	**$**	☐ Yes ☐ No ☐ I don't know
Person 2:		☐ Is enrolled now ☐ Plans to enroll *Start date* _____ ☐ Is not enrolled	**$**	☐ Yes ☐ No ☐ I don't know
Person 3:		☐ Is enrolled now ☐ Plans to enroll *Start date* _____ ☐ Is not enrolled	**$**	☐ Yes ☐ No ☐ I don't know
Person 4:		☐ Is enrolled now ☐ Plans to enroll *Start date* _____ ☐ Is not enrolled	**$**	☐ Yes ☐ No ☐ I don't know

What change will the employer make for the new plan year (if known)?

☐ Employer won't offer health coverage.

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the **minimum value standard.*** (Premium should reflect the discount for wellness programs.)

How much will the employee have to pay in premiums for that plan? **$** _____

How often? _____

☐ Weekly ☐ Every 2 weeks ☐ Quarterly
☐ Monthly ☐ Twice a month ☐ Yearly

Date of change _____

***Minimum value standard** means that a plan pays at least 60% of the total cost of plan benefits provided to the employee. (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

Need help? Call Covered California at **1-800-300-1506** (TTY: 1-888-889-4500). The call is free. You can call Monday to Friday, 8 a.m. to 8 p.m., and Saturday, 8 a.m. to 6 p.m. Or visit **CoveredCA.com**.

Attachment D: Choose your pediatric dental plan and your health insurance plan

★ If you need to tell us about more than four people who would like to choose a pediatric dental plan or health insurance plan, **make a copy of this page and the next page,** and be sure to send them with your application.

If you think you qualify for premium assistance, write the name or metal tier of the pediatric dental plans or health insurance plans you want below. To learn more about private plans provided by Covered California, visit **CoveredCA.com** or call **1-800-300-1506** (TTY: 1-888-889-4500).

If you think you qualify for Medi-Cal, write the name of the health insurance plan you want below. To learn more about available Medi-Cal plans in your county, or to change your plan once you are enrolled, call Health Care Options at **1-800-430-4263** (TTY: 1-800-430-7077), or visit **healthcareoptions.dhcs.ca.gov**.

To see if you qualify for Medi-Cal or premium assistance, look at Attachment F.

▶ Choose your Covered California pediatric dental plan *for children 18 or younger only*

Name *First, middle, last, suffix (for example, Jr., Sr., III, IV)*	**Pediatric dental plan name**	**Coverage level**	**Plan type**
Child 1:		☐ High ☐ Low	☐ DEPO ☐ DPPO ☐ DHMO
Child 2:		☐ High ☐ Low	☐ DEPO ☐ DPPO ☐ DHMO
Child 3:		☐ High ☐ Low	☐ DEPO ☐ DPPO ☐ DHMO
Child 4:		☐ High ☐ Low	☐ DEPO ☐ DPPO ☐ DHMO

DEPO–Dental Exclusive Provider Organization; DHMO–Dental Health Maintenance Organization; DPPO–Dental Preferred Provider Organization

▶ Choose your health insurance plan

Medi-Cal and Covered California plans		Covered California plans only		
Name *First, middle, last, suffix (for example, Jr., Sr., III, IV)*	**Health plan name**	**Metal tier**	**Metal number**	**Plan type**
Person 1:		☐ Platinum ☐ Gold ☐ Silver ☐ Bronze ☐ Minimum coverage plan		☐ EPO ☐ HMO ☐ HSA ☐ PPO
Person 2:		☐ Platinum ☐ Gold ☐ Silver ☐ Bronze ☐ Minimum coverage plan		☐ EPO ☐ HMO ☐ HSA ☐ PPO
Person 3:		☐ Platinum ☐ Gold ☐ Silver ☐ Bronze ☐ Minimum coverage plan		☐ EPO ☐ HMO ☐ HSA ☐ PPO
Person 4:		☐ Platinum ☐ Gold ☐ Silver ☐ Bronze ☐ Minimum coverage plan		☐ EPO ☐ HMO ☐ HSA ☐ PPO

EPO–Exclusive Provider Organization; HMO–Health Maintenance Organization; HSA–Health Savings Account (this plan type allows members to open and contribute to a Health Savings Account); PPO–Preferred Provider Organization

To complete plan selection, all individuals age 18 or older who are selecting a health insurance plan must agree to and sign the arbitration agreement on the next page.

***Attachment D** continued on next page*

Need help? Call Covered California at **1-800-300-1506** (TTY: 1-888-889-4500). The call is free. You can call Monday to Friday, 8 a.m. to 8 p.m., and Saturday, 8 a.m. to 6 p.m. Or visit **CoveredCA.com**.

Attachment D: Choose your Covered California plans *(continued)*

Agreement for Binding Arbitration

▶ For each person who selects a Covered California plan:

I understand that every participating health plan has its own rules for resolving disputes or claims, including, but not limited to, any claim asserted by me, my enrolled dependents, heirs, or authorized representatives against a health plan, any contracted health care providers, administrators, or other associated parties, about the membership in the health plan, the coverage for, or the delivery of, services or items, medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), or premises liability.

I understand that, if I select a health plan that requires binding arbitration to resolve disputes, I accept, and agree to, the use of binding arbitration to resolve disputes or claims (except for Small Claims Court cases and claims that cannot be subject to binding arbitration under governing law) and give up my right to a jury trial and cannot have the dispute decided in court, except as applicable law provides for judicial review of arbitration proceedings. I understand that the full arbitration provision for each participating health plan, if they have one, is in the health plan's coverage document, which is available online at **CoveredCA.com** for my review, or, I can call Covered California at **1-800-300-1506** (TTY: 1-888-889-4500) for more information.

▶ For each person who selects a Kaiser Medi-Cal health plan:

Notice of binding arbitration: I have read the plan description. I understand that Kaiser requires the use of binding neutral arbitration to resolve certain disputes. This includes disputes about whether the right medical treatment was provided (called medical malpractice) and other disputes relating to benefits or the delivery of services, including whether any medical services provided were unnecessary or unauthorized, or were improperly, negligently, or incompetently rendered. If I pick Kaiser as my Medi-Cal health plan, I give up my constitutional right to a jury or court trial for those certain disputes. I also agree to use binding neutral arbitration to resolve those certain disputes. I do not give up my right to a state hearing of any issue, which is subject to the state hearing process.

▶ Signatures of enrollees for **all** plans

Signature of **Person 1**, or responsible party, or authorized representative for Person 1, if at least 18 years old ▶	Date
Signature of **Person 2**, or responsible party, or authorized representative for Person 2, if at least 18 years old ▶	Date
Signature of **Person 3**, or responsible party, or authorized representative for Person 3, if at least 18 years old ▶	Date
Signature of **Person 4**, or responsible party, or authorized representative for Person 4, if at least 18 years old ▶	Date