Person # _____

Family of # _____

COVERED CALIFORNIA

Insurance Solutions
Solving your insurance questions

First name	Middle name	Last name	Suffix

Home Address Apartment #

City	State	Zip code	Are you: ☐Male ☐Female

Phone number	Language	Email

Are you: ☐Single ☐Married ☐Divorced ☐Registered domestic partner ☐Widowed

☐Social Security ☐ITIN ☐ATIN

Date of Birth (month / day / year)	Age	Are you applying for health insurance for yourself? ☐Yes ☐No

What is your relation to Person #1? *(If necessary)*	Special Enrollment Type (SEP)? *(if applicable)*

Are you the primary tax filer? ☐ 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

Job 1: Employer name:_____How much? $_____How often?☐Yr ☐Mo ☐Biweekly
Job 2: Employer name:_____How much? $_____How often?☐Yr ☐Mo ☐Biweekly
Self-employed: Type of work:_____What is your monthly income? $_____
Other Income: Type of work: _____What is your monthly income? $_____
Any additional information on income?

Have you lived in the U.S. since 1996? ☐ Yes ☐ No
Are you a U.S. Citizen or U.S. national? ☐ Yes ☐ No
If you checked no, do you have any satisfactory immigration status? ☐Yes ☐ No
Document type: _____ Name on document: _____
ID number: _____ Alien number: _____
Country of issuance: _____ Expiration date: _____

Effective Date:	Quote: $ /mo.	On or Off Exchange? ☐ On ☐ Off

Notes/comments:

Choose your health insurance plan.

Name	Health plan name	Metal tier	Metal number	Plan type
Person # _____		☐ Platinum ☐ Gold ☐ Silver ☐ Bronze ☐ Minimum coverage plan		☐ EPO ☐ HMO ☐ HSA ☐ PPO

Signature of **Person 1**, or responsible party, or authorized representative, if at least 18 years old. Date

▶ _____

Certified Insurance Agent ***(Please Print)***

Name: _____ License number: _____