**Covered California Proof of Coverage**

**{Year} {Quarter}**

**{Date Generated}**

This document provides information about health coverage received by the member identified below through Covered California. Please note that all health plans offered through Covered California meet the federal and state requirements for Minimum Essential Coverage.

Reference Number: {XXXXXXX}

Covered Member: {First Name} {Last Name} {suffix}

Address: {Street Address Line 1}

{Street Address Line 2}

{City}, {State Code} {Zip Code}

Date of Birth: {MM/DD/YYYY}

Health Plan Name: {Carrier Name}

|  |  |  |  |
| --- | --- | --- | --- |
| Covered Months: {Year} {Quarter} | | | |
| All Months | {Month 1} | {Month 2} | {Month 3} |
|  |  |  |  |

The enrollment status of the individual named above reflects available data as of the time this report was generated and is intended only for informational purposes. This report may not reflect recent changes to an individual’s enrollment status, such as coverage falling into an applicable grace period or retroactive cancellation of coverage. Covered California is not liable for any inaccuracies in this report, including those due to changes in enrollment status, data errors, or other discrepancies.

Your destination for affordable health insurance including, Medi-Cal

**Covered California**

**P.O. Box 989725**

**West Sacramento, CA 95798-9725**