

Explanation of Health Coverage

Provide your account information

Full Name of Account Holder:

Date of Birth:

Connect for Health Colorado Account #:

Mailing Address:

Email Address:

Phone Number:

This form is to confirm that _____ (print your name here) does not qualify for and is not enrolled in any of the following types of health coverage:

- Medicare (you do not qualify for premium-free Medicare Part A)
- TRICARE
- Health care through the Department of Veterans Affairs (VA)
- Peace Corps

Agreement and signature

By signing this form, I agree:

- I have carefully reviewed my Connect for Health Colorado account and application and all information is true and correct to the best of my knowledge.
- The information in my application will be used to determine if I qualify for Premium Tax Credits (lower monthly costs) and/or Cost-Sharing Reductions (lower out-of-pocket costs).
- It is my responsibility to **update my application within 30 days if any information in my application changes**, including household size, income, living situation, and access to other health coverage.
- I am aware of the potential tax consequences if the information I provided in my application or in this form is different than what I report when I file my federal income taxes. I also understand that if I provide false information on purpose, I may have to pay back the assistance I received and/or not get assistance in the future.
- This form must be returned by the due date I was given by Connect for Health Colorado to provide proof that I am not enrolled in or do not qualify for other health coverage.
- Information on this form may be checked by electronic data sources and/or the Connect for Health Colorado Verification Department.

Signature:

Date: