STATE OF CALIFORNIA
CALIFORNIA HEALTH BENEFIT EXCHANGE/COVERED CALIFORNIA (Exchange/CC)

NOTIFICATION OF DECEASED – BY ESTATE REPRESENTATIVE
HBEX 411c (09/17)

Notification of Deceased by an Estate Representative

Please complete this form if you have legal authority to act on behalf of the deceased Consumer's estate. The change in household size will result in a termination of coverage (if the deceased was the sole enrollee) or a redetermination of eligibility for remaining enrollees. Please allow 30 days for processing. The form maybe be mailed or faxed to the following.

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

Fax: (888) 329-3700

Deceased Consumer's Information *(As indicated on the Covered California Account)*		
Last Name:	First Name:	Middle Initial:
Address:	City/State:	Zip Code:
Covered California Case or Account Number:		Date of Birth:

Estate Representative's Information		
Last Name:	First Name:	Middle Initial:
Address:	City/State:	Zip Code:
Daytime Phone Number *(Required)*	Email Address:	

Additional Information		
Do you need a copy of the previous year's IRS form 1095A	Yes ☐	No ☐
Does the mailing address on the account need to be updated for future correspondence and the current year tax information?	Yes ☐	No ☐
What is the new address?		

Additional Information cont.
Any Additional Instructions?
Please include copy of one the following documents: **Death Certificate, Obituary, Medical Record, Power of Attorney, Proof of Executor or Proof of Estate.**
What legal authority do you have to act on behalf of the Consumer? Please attach one of the following legal documents to support your authority: 1. **Trust Documents -** Title page, trustee page & signature page 2. **Power of Attorney** 3. **Other Legal Documents –** Court order, Consumer's Will, etc.

Attached Copy of Estate Representative's Identifying Information. *(If no identifying document is attached, your signature must be notarized.)*	
Driver's License ☐	Identification Card ☐
Federal Issued Identification Card ☐	Notary ☐
Date Notarized:	UNOFFICIAL UNLESS STAMPED BY NOTARY PUBLIC
Notarized By:	
Notary Public Number:	

Authorized Representative's Signature	
I understand Covered California may not be able to comply with my request but will provide me with a response. I declare under penalty of perjury that the information on this form is true and correct.	
Signature:	Date:
The information requested on this form is required by the California Health Benefit Exchange to process your request and will be used solely for this purpose. Failure to provide this information may result in the denial of your request. Legal references authorizing the collection or maintenance of the information provided on this form include Sections 1798.22, 1798.25, 1798.27 and 1798.35 of the California Civil Code and Section 155.260(a) of the Code of Federal Regulations. California Health Benefit Exchange, Privacy Office, 1601 Exposition Blvd, Sacramento, CA 95815 (800) 889-3871.	