ConnectiCare

Qualifying Event Attestation

An individual can experience a **qualifying event** that makes him/her eligible to apply for health care coverage outside the Open Enrollment Period. This is called a **Special Enrollment Period**. This Attestation attests to my eligibility for Special Enrollment Period. By signing below, I hereby attest to the following:

To the best of my knowledge, I am eligible to apply because I have experienced the qualifying event selected below on _____/_____/_____:
Month Day Year

- ☐ **Lost my coverage**
  An individual and/or any dependents lose Minimum Essential Coverage (MEC) not resulting from failure to pay premium or providing false information on a previous application
- ☐ **I lost my employer group coverage**
  - ☐ Termination of employment
  - ☐ Death of a covered employee
  - ☐ Covered employee's eligibility for Medicare
  - ☐ Reduction in the number of hours
  - ☐ Employer no longer offers health coverage
- ☐ **Gained or became a dependent**
  - ☐ Through Marriage
  - ☐ Birth, adoption, or placement for adoption or foster care
- ☐ **Other reasons**
  - ☐ Child support order or other court order
  - ☐ Divorce or legal separation
  - ☐ End of Dependent status (dependent turned 26)
  - ☐ An individual gets medical confirmation of a pregnancy by a licensed health care provider, in writing, within the first 30 days of the commencement of the pregnancy
  - ☐ Change in eligibility for advanced premium tax credits or cost sharing reductions
  - ☐ Moved into the ConnectiCare service area
  - ☐ Error in enrollment
  - ☐ Plan or other carrier violated a provision of the contract for my plan
  - ☐ Released from Incarceration (jail or prison)

- I understand that I am required to provide proof of my qualifying event and coverage will not begin until ConnectiCare receives and validates this proof
- I understand and agree that if I have knowingly provided incorrect or incomplete information, ConnectiCare may rescind my policy within 2 years of issuance, which means that ConnectiCare will cancel coverage as if the policy never existed
- I acknowledge that any person/company that suffers any loss due to any false statement contained in this Attestation may bring a civil action against me to recover his/her losses, including attorney fees
- I understand that any act, practice or omission that constitutes fraud or intentional misrepresentation of material fact found in this Attestation/Application is a crime punishable by penalties, imprisonment and/or restitution depending on applicable laws and may result in the denial of benefits, rescission or cancellation of my coverage

_____
Print Name

_____
Signature Date