



## Health Insurance Attestation Form

I, \_\_\_\_\_, attest that I have Health Insurance that meets the requirements of the Affordable Care Act (ACA) either through private insurance or Covered California. I understand it is my responsibility to inform RNI should my policy change or I no longer have coverage.

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_