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

REQUEST TO AMEND PERSONAL INFORMATION BY A PARENT, GUARDIAN, OR PERSONAL REPRESENTATIVE

HBEX 410 (8/15)

Request to Amend Personal Information by a Parent, Guardian, or Authorized Representative

As the Consumer's Authorized Representative, you may request amendments to the Consumer's personal information Covered California creates or maintains for the Consumer. You will receive a response to your request within 30 days after we receive your request. Should we deny your request, you have the right to request a review of our decision and we will provide you the name and contact information of the reviewing official in conjunction with a written copy of our decision. Please complete this form and attach all relevant documents. You may submit the form and documents by either mail or fax.

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

Fax: (888) 329-3700

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

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

Identify the Personal Information in the Consumer's record you want to amend, and why you

What should the Consumer's record state?

What legal authority do you have to act on behalf of the Consumer? *(Please attached legal documentation.)*					
Parent	☐	Conservator	☐	Executor of Will	☐
Guardian	☐	Agent of Health Care	☐	Power of Attorney	☐
Other	☐				

Attached Copy of Representative's Identifying Information. *(If no identifying document is attached, your signature must be notarized.)*	
Driver's License ☐	State 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 Benefits Exchange, Privacy Office in order to process your request. The information you provide on this form is required to process your request and will be used by the Privacy Office for that 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 Benefits Exchange, Privacy Office, 1601 Exposition Blvd, Sacramento, CA 95815 (800) 889-3871.