STATE OF CALIFORNIA
CALIFORNIA HEALTH BENEFIT EXCHANGE

HEALTHCARE EVIDENCE INITIATIVE FOR MY OWN HOUSEHOLD
HBEX 1000 (10/16)

I WOULD LIKE TO OPT-OUT OF THE HEALTHCARE EVIDENCE INITIATIVE FOR MY OWN HOUSEHOLD

If you are currently enrolled in a qualified health plan, you may submit an opt-out request to remove future personal information from the Healthcare Evidence Initiative (HEI). The Covered California's HEI uses data to improve the patient experience of care, and lower costs for consumers. Opt-out requests will take effect in the month after they are received from Covered California, and remain in effect for the consumer's case ID into future years. If you would like to opt-out of the HEI, complete and mail this form, along with supporting documentation to: Covered California P.O. Box 989725 West Sacramento, CA 95798-9725

Please note that you must be the authorized representative for your household to opt-out of the Covered California Healthcare Evidence Initiative.

For additional information regarding the Covered California HEI project, please visit www.CoveredCA.com/notices or call 1-800-300-1506.

INDIVIDUAL REQUESTING TO OPT-OUT OF THE HEALTHCARE EVIDENCE INITIATIVE		
LAST NAME: Required	FIRST NAME: Required	MIDDLE INITIAL:
ADDRESS:	CITY/STATE:	ZIP CODE:
COVERED CALIFORNIA CASE ID: Required	DATE OF BIRTH: Required	PHONE #:

IDENTITY VERIFICATION

(Please attach a copy of one of the following. If no identifying document is attached, your signature must be notarized.)

☐ BIRTH CERTIFICATE	☐ DMV IDENTIFICATION CARD
☐ CALIFORNIA DRIVER'S LICENSE	☐ STATE OR FEDERAL ISSUED ID CARD

NUMBER:	UNOFFICIAL UNLESS STAMPED BY NOTARY PUBLIC
NOTARIZED BY:	
NOTARY PUBLIC NUMBER:	

SIGNATURE

By signing below, I represent that I am the authorized representative for my household and that I have all necessary legal authority to request that information about me and my household be omitted from the Healthcare Evidence Initiative. I understand that Covered California reserves the right to require additional documentation or other evidence of my authority to make this request.

(printed name)	(signature)	(date)