TAXABLE YEAR **2021**

# California Health Insurance Marketplace Statement

CALIFORNIA FORM **3895**

☐ VOID ☐ CORRECTED

| Recipient's name | Initial | Last name | Suffix | Recipient's SSN | Recipient's date of birth |
|---|---|---|---|---|---|
| | | | | | |
| **Spouse's first name** | **Initial** | **Last name** | **Suffix** | **Spouse's SSN** | **Spouse's date of birth** |
| | | | | | |

Address (apt./ste., room, PO box, or PMB no.)

| City | State | ZIP code |
|---|---|---|
| | | |

| Marketplace identifier | Marketplace-assigned policy number | Policy issuer's name |
|---|---|---|
| | | |
| **Policy start date** | **Policy termination date** | ☐ Repayment cap may not apply |
| | | |

## Part I Covered Individuals

| | (a) Covered individual name | | (b) Covered individual SSN | (c) Covered individual date of birth | (d) Coverage start date | (e) Coverage termination date |
|---|---|---|---|---|---|---|
| | First name | Last name | | | | |
| 1 | | | | | | |
| 2 | | | | | | |
| 3 | | | | | | |
| 4 | | | | | | |
| 5 | | | | | | |

## Part II Coverage Information

| Month | (a) Monthly enrollment premiums | (b) Monthly second lowest cost silver plan (SLCSP) premium | (c) Monthly advance payment of premium assistance subsidy |
|---|---|---|---|
| 6 January | | | |
| 7 February | | | |
| 8 March | | | |
| 9 April | | | |
| 10 May | | | |
| 11 June | | | |
| 12 July | | | |
| 13 August | | | |
| 14 September | | | |
| 15 October | | | |
| 16 November | | | |
| 17 December | | | |
| 18 **Annual Totals** | | | |