

# CCA APPLICATION

- ☐ NEW ☐ KEEP CARRIER  
☐ NO SUB ☐ CHANGE CARRIER  
☐ NEW Medi-Cal ☐ AUTO RENEW

File # \_\_\_\_\_ Date: \_\_\_\_\_ Assisted by: \_\_\_\_\_  
Phone#: \_\_\_\_\_ Wechat# \_\_\_\_\_  
Primary Name: \_\_\_\_\_  
Case#: \_\_\_\_\_ ☐ Existing Mixed Case

Please Check All That Apply

- ☐ Valid Citi ☐ Change Status ☐ Need update Citi Doc ☐ Delegated Agent  
☐ Need update income (Old income on CCA \$ \_\_\_\_\_) ☐ Reapply  
☐ Change plan From \_\_\_\_\_ to \_\_\_\_\_ ☐ DW  
☐ Change household size from \_\_\_\_\_ to \_\_\_\_\_  
☐ Add / Remove (Primary, Spouse, Child, Parent) \_\_\_\_\_ on Household / Policy  
☐ Add / Remove (Primary, Spouse, Child, Parent) \_\_\_\_\_ on Household / Policy

Reason: \_\_\_\_\_ (Must attach initial payment if Remove or Add Primary)

- ☐ Correct NAME/DOB/SSN (Must attach updated Citi Doc, SSN, & Driver's License Copy)

Name \_\_\_\_\_ from: \_\_\_\_\_ to \_\_\_\_\_

- ☐ Change Mailing / Resident to : \_\_\_\_\_

- ☐ Note: \_\_\_\_\_

Zip Code \_\_\_\_\_

Household Size \_\_\_\_\_

- ☐ Attached Attest of Income

**Enroll** **Age** **Total Annual Income \$** \_\_\_\_\_ ☐ Signed Delegation

- ☐ Primary \_\_\_\_\_ P/S \_\_\_\_\_ wk/ twice/ bi-wk/ mo/ yr / SE  
☐ Spouse \_\_\_\_\_ P/S \_\_\_\_\_ wk/ twice/ bi-wk/ mo/ yr / SE  
☐ Dependent \_\_\_\_\_ P/S \_\_\_\_\_ wk/ twice/ bi-wk/ mo/ yr / SE  
☐ Dependent \_\_\_\_\_ P/S \_\_\_\_\_ wk/ twice/ bi-wk/ mo/ yr / SE  
☐ Dependent \_\_\_\_\_ Employer's Name & Address if not shown on Paystub/W2  
\_\_\_\_\_

- ☐ Need choose PCP

Dr Name \_\_\_\_\_

Zip Code \_\_\_\_\_

Phone# \_\_\_\_\_

IPA \_\_\_\_\_

Enrolled Member #: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Carrier: \_\_\_\_\_ ☐ 2 Enrollment Groups

Plan name: \_\_\_\_\_ PPO / HMO / HSA

Premium: \_\_\_\_\_ - \_\_\_\_\_ = \_\_\_\_\_ ☐ No Sub

Request Eff. Date: \_\_\_\_\_

- ☐ Email

Account Holder's Name \_\_\_\_\_

**Initial / EFT**

- ☐ Phone

Visa/Master \_\_\_\_\_ Exp \_\_\_\_/\_\_\_\_ CVC \_\_\_\_\_

- ☐ Text

Routing # \_\_\_\_\_ Account # \_\_\_\_\_

- ☐ Wechat \_\_\_\_\_

Bank Name \_\_\_\_\_ Billing Zip Code \_\_\_\_\_

Billing Address \_\_\_\_\_

Cash Receipt # \_\_\_\_\_ \$ \_\_\_\_\_

**Signature 簽名**



File # \_\_\_\_\_

AUTHORIZATION TO DELEGATE AGENT

委托代理人授权书

我 \_\_\_\_\_ 授權亞裔社區中心及保險服務作為我全民健保的保險代理人。我明白若要解除代理權，必須以書面形式通知。我同意亞裔社區中心協助本人更改任何資料，包括代為改回被無故修改的代理權。

I, \_\_\_\_\_ authorize and delegate my Covered California case to Apac Service Center and Insurance Services as my Covered California insurance agent. I understand I am required to inform Apac Service Center in writing if I wish to delegate my case to another agent. Apac Service Center is authorized to help me adjust any changes on the application, which includes the rights to re-delegate my case back to Apac Service Center if written request has not been received and case has been delegated elsewhere.

APPLICANT'S FULL NAME (Print): \_\_\_\_\_

申请人的全名

APPLICANT'S LAST 4 DIGITS OF SSN: \_\_\_\_\_

申请人 SSN 的最后 4 位数字:

CASE ID# (If application already initiated): \_\_\_\_\_

APPLICANT'S SIGNATURE: \_\_\_\_\_

申请人签名

DATE: \_\_\_\_\_

日期