TAXABLE YEAR **2020**

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			