TAXABLE YEAR

2023

California Health Insurance Marketplace Statement

CALIFORNIA FORM

3895

	VOID		CORRE	CTE)								
Recipient's name				Initial		Last name		Suffix	Recipient	nt's SSN		Recipient's date of birth	
Spous	se's first name			ı	Initial	Last name		Suffix	Spouse's SSN			Spouse	's date of birth
Address (apt./ste., room, PO box, or PMB no.)													
City											State	ZIP cod	le
Marketplace identifier						Marketplace-assigned policy number Policy iss					iame	I	
Policy	start date					Policy termination date			F	Repayment cap may not apply			
Par	t I Covered Ir	ndivid											
		Cov	(a) ered indivi	idual n	am_		(b) Covered	(c Covered in) ndividual	(d) Coverage		ue	(e) Coverage
	First name					ast name	individual SSN	date of	f birth start d		start da	ate	termination date
1													
2													
3													
4													
5													
Par	t II Coverage	Info	rmation			(a)	/L\					1.	-)
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													
	ecember												
	nnual Totals												