Attestation for Proof of Minimum Essential Coverage (MEC)

Please complete the following to provide information on your current health coverage.

I am attesting to the following:

I, _____, am covered under the following health coverage:

Health Coverage Provider:_____

Policy # _____ Group ID# _____.

The coverage meets or exceeds requirements for minimum essential coverage (MEC).

If applicable, the following family member(s) are also covered under the same health coverage as listed above:

_____
Name(s)

If coverage for family member(s) is through a different health coverage provider:

The following family member(s) is/are covered under the following health coverage:

_____
Name(s)

Health Coverage Provider:_____

Policy # _____ Group ID# _____.

The coverage meets or exceeds requirements for minimum essential coverage (MEC).

I have included copies of proof of coverage from the health coverage provider, listing the names of each person covered under the plan.

I will promptly contact my employer if there are any changes to my or my family's health coverage and submit a new form with the updated information.

_____ _____
Signature Date

**Minimum Essential Coverage (MEC) is any health coverage that meets the requirements of the Affordable Care Act (ACA), ensuring individuals have a baseline level of health protection and fulfilling the ACA's individual mandate.

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