

# Letter of Explanation to Confirm Life Events

If you get a notice from the Marketplace saying that you need to submit documents to confirm a life event, you can upload or mail copies of those documents to the Marketplace. In some cases, you can submit a written explanation if you don't have any of the other documents we asked you to send us.

To do this, save this file to your computer, fill out the section related to your life event and upload it to your Marketplace account on [HealthCare.gov](https://www.healthcare.gov). If you need more room, you can continue on another sheet of paper.

To upload your letter, log into your Marketplace account and select the application with the life event. Select "Application details" on the left-hand menu. Under "Send confirmation for your Special Enrollment Period," choose the "Upload documents" button. In the document type list, select "Letter of explanation." Or, you can mail a copy to: Health Insurance Marketplace, Attn: Coverage Processing, 465 Industrial Blvd., London, KY 40750-0001. Include the printed bar code page from your notice. Visit [HealthCare.gov/tips-and-troubleshooting/uploading-documents](https://www.healthcare.gov/tips-and-troubleshooting/uploading-documents) for more information.

Your Name \_\_\_\_\_

Your Application ID \_\_\_\_\_

You only need to write your Application ID if you're mailing this document. Your Application ID is at the top of your notice near your mailing address, or online in your Marketplace account.

## Loss of Coverage

What kind of coverage did you/do you have?

When did you/will you lose your coverage?

\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
MM DD YYYY

Why are you losing your coverage?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Why can't you submit the requested documents?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Move

Check this box if you had health coverage at least one day during the 60 days before your move.

Check this box if you moved from a foreign country or U.S. territory.

What's your old address?

When did you move?

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
MM DD YYYY

What's your new address?

\_\_\_\_\_  
\_\_\_\_\_

Why can't you submit the requested documents?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Marriage

Write the names of the people who got married.

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When did they get married?

     /      /       
MM    DD    YYYY

Check this box if either or these people had health coverage at least one day during the 60 days before getting married.

Is there any other information you'd like to include about this marriage?

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Why can't you submit the requested documents?

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## Denial of Medicaid or CHIP Coverage

Write the name of each person on your application who was denied coverage through Medicaid or CHIP.

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When were these people denied coverage?

     /      /       
MM    DD    YYYY

Why can't you submit the requested documents?

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## Adoption, Foster Care Placement, or Court Order

Write the name of each person on your application who became a new dependent due to adoption, foster care placement, or a court order.

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When did they become a new dependent?

     /      /       
MM    DD    YYYY

Is there any other information you'd like to include about the adoption, foster care placement, or court order?

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Why can't you submit the requested documents?

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You have the right to get Marketplace information in an accessible format, like large print, Braille, or audio.

You also have the right to file a complaint if you feel you've been discriminated against.

Visit [CMS.gov/About-CMS/Agency-Information/Aboutwebsite/CMSNondiscriminationNotice](https://www.cms.gov/About-CMS/Agency-Information/Aboutwebsite/CMSNondiscriminationNotice), or call the Marketplace Call Center at 1-800-318-2596 for more information. TTY users can call 1-855-889-4325.

## Health Insurance Marketplace

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This product was produced at U.S. taxpayer expense.

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