



REQUEST FOR PROOF OF COVERAGE

(January 1, 2026 through December 31, 2026)

Confirmation of proof of coverage/enrollment for: _____

Section 1: Medical Insurance Coverage Verification

___ Does Not Have Coverage (skip to Section 2)

___ Has Coverage (please provide additional information):

Name of Insurance Company:	
Name of Policy Holder:	Subscriber ID:
Covered Dependent(s) & Relationship to Policy Holder:	
Effective Date of Coverage:	
Coverage Estimated to Last Until 12/31/2026? ___ Yes ___ No - Estimated to End:	
Is this coverage considered "Group Coverage," not purchased on the individual market (including through Covered California), and meets the standards of affordable, minimum value coverage as defined by the Affordable Care Act?	___ Yes ___ No

Section 2: Dental Insurance Coverage Verification

___ Does Not Have Coverage (skip to Section 3)

___ Has Coverage (please provide additional information):

Name of Insurance Company:	
Name of Policy Holder:	Subscriber ID:
Covered Dependent(s) & Relationship to Policy Holder:	
Effective Date of Coverage:	
Coverage Estimated to Last Until 12/31/2026? ___ Yes ___ No - Estimated to End:	

Section 3: Employer/Benefits Representative

By my signature below, I hereby confirm the above is true and correct.

Signature

Printed Name

Date

Title

Company Name

Phone

Email Address

PLEASE COMPLETE AND SEND TO: HRBENEFITS@SANTA-ANA.ORG OR FAX (714) 647-6930