Version 2

Cook County Health Self- Attestation Letter of Insurance

Patient's Name: _____

MRN: _____

Put an "X" next to the statement that best describes your situation

_____I do not have access to affordable health insurance through my employer, my spouse's employer or through the Marketplace now or in the foreseeable future.

_____I have requested the information from my employer, but I have been unable to obtain it.

Additionally, I understand that at any time I obtain health insurance, I will inform Cook County Health within the first 30 days from receiving health insurance.

I certify that the information I have provided on this form is true, correct, and complete to the best of my knowledge.

Patient Signature _____ Date _____