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## 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 \_\_\_\_\_