



## ATTESTATION OF OTHER INCOME

Instruction: Complete this Attestation if you have no other documents to verify the income you provided on your Get Covered New Jersey coverage application. Call the Customer Assistance Center at 833-677-1010 to see if you should use this form.

NAME: \_\_\_\_\_

APPLICATION ID: \_\_\_\_\_ SSN OR TAX ID: \_\_\_\_\_

1. I, \_\_\_\_\_, attest and affirm that the current monthly Income of my household is \$ \_\_\_\_\_.

2. The source of this income is \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_.

3. My monthly income has changed recently due to the following: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_.

4. I understand that if I am determined eligible for a Qualified Health Plan that I must report any changes (including income, address, household members and pregnancy status) within 30 days to GetCoveredNJ because it may affect the amount of premium assistance (or tax credits) or the level of cost-sharing reduction for which I may qualify, and I can do this by logging into my online account at [GetCovered.nj.gov](http://GetCovered.nj.gov) or by calling the Call Center at 1-833-677-1010. I understand that if I receive too much premium assistance (or tax credits) during the benefit year, I will have to pay some or all of the excess premium assistance back to the Internal Revenue Service (IRS) when I file my federal income tax return for the benefit year.

5. I declare under penalty of perjury and certify that the foregoing statements made by me are true and correct. I am aware that if any of the foregoing statements made by me are willfully false, I am subject to punishment.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE