Marketplace Application Review

AGREEMENTS

1. To make it easier to determine my eligibility for help paying for coverage in future years, I agree to allow the Marketplace to use my income data, including information from tax returns, for the next five years. The Marketplace will send me a notice, let me make changes, and I can opt out at any time.

2. I understand that I'm not eligible for a premium tax credit if I'm found eligible for other qualifying health coverage like Medicaid, Children's Health Insurance Program(CHIP), or a job-based health plan. I also understand that if I become eligible for other qualifying health coverage, I must contact the marketplace to end my Marketplace coverage and premium tax credit. If I don't, the person who files taxes in my household may need to pay back my premium tax credit.

3. I understand that because the premium tax credit will be paid on my behalf to reduce the cost of health coverage for myself and/or my dependents:

   - I must file a federal income tax return for the 2024 tax year.
   - If I'm married at the end of 2024, I must file a joint income tax return with my spouse.

   I also expect that:

   - No one else will be able to claim me as a dependant on their tax return.
   - I'll claim a personal exemption deduction on my federal tax return for any individual listed on this application as my dependent who is enrolled in coverage through this Marketplace, and whose premium for coverage is paid in whole or in part by advance payments of the premium tax credit.

   If any of the above changes:

   - I understand that it may impact my ability to get the premium tax credit.
   - I also understand that when I file my federal income tax return, the Internal Revenue Service (IRS) will compare the income on my tax return with the income on my application. I understand that if the income on my tax return is lower than the income on my application, I may be eligible to get additional premium tax credit amount. On the other hand, if the income on my tax return is higher than the amount of income on my application, I may owe additional federal income tax.

4. If anyone on this application enrolls in Medicaid, I'm giving the Medicaid agency our rights to pursue and get money from other health insurance, legal settlements or other third parties. I'm also giving the Medicaid agency rights to pursue and get medical support from a spouse or parent.

5. I know that I must tell the program I'll be enrolled in if the information I listed on my application changes. I know I can make changes in my Marketplace account or by calling the Marketplace Call Center at 1-800-318-2596. I know a change in my information could affect eligibility for members of my household.

6. If anyone on your application is enrolled in Marketplace coverage and is also found to have Medicare coverage, the Marketplace will automatically end their Marketplace plan coverage. They will get a notice before the Marketplace terminates their coverage in case they need to keep it or make changes. During all months of overlapping coverage, they're responsible for paying the full cost for the Marketplace plan premium and covered services.

7. I have reviewed my application and confirm it to be accurate in compliance with §155.227. This includes but is not limited to, information related to my contact profile (email, phone number, and address) as well as my income reported to the exchange.

I am signing this application under penalty of perjury, which means I have provided true answers to all the questions on this application to the best of my knowledge. I know that I may be subject to penalties under federal law if I intentionally provide false information.

I have reviewed my Marketplace Eligibility Notice and I have authorized my representative to electronically sign my online Marketplace application on my behalf that we completed together.

AGENT NAME: _____

AGENT NPN: _____

AGENCY NAME: _____

AGENCY NPN: _____

NAME OF PRIMARY
HOUSEHOLD CONTACT
(AND/OR AUTHORIZED REPRESENTATIVE): _____

SIGNATURE: _____

DATE OF CONSENT: _____