

Consent For Broker Assistance

I, _____, give my permission to _____ to serve as the health insurance agent or broker for myself and my entire household if applicable, for purposes of enrollment in a Qualified Health Plan offered on the Federally Facilitated Marketplace. By consenting to this agreement, I authorize _____ to view and use the confidential information provided by me in writing, electronically, or by telephone only for the purposes of one or more of the following:

1. Searching for an existing Marketplace applicataion;
2. Completing an application for eligibilty and enrollment in a Marketplace Qualified Health Plan or other government insurance affordability programs, such as Medicaid and CHIP or advance tax credits to help pay for Marketplace premiums;
3. Providing ongoing account maintenance and enrollment assistance, as necessary; or
4. Responding to inquiries from the Marketplace regarding my Marketplace application.

I understand that _____ will not use or share my personally identifiable information (PII) for any purposes other than those listed above. _____ will ensure that my PII is kept private and safe when collecting, storing, and using my PII for the stated purposes above. I confirm that the information I provide for entry on my Marketplace eligibility and enrollment application will be true to the best of my knowledge. I understand that I do not have to share additional personal information about myself or my health with _____ beyond what is required on the application for eligibility and enrollment purposes.

I understand that my consent remains in effect until I revoke it, and I may revoke or modify my consent at any time by notifying _____ in writing.

AGENT NAME: _____

AGENT NPN: _____

AGENCY NAME: _____

AGENCY NPN: _____

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

SIGNATURE: _____

DATE OF CONSENT: _____

