Consent Form and Eligibility Attestation for Marketplace Agents and Brokers

I,_____ [insert name of primary household contact], give my permission to_____[insert name of the person or entity who has the consumer's consent] to serve as the health insurance broker for myself and my entire household, if applicable, for purposes of enrollment in a Qualified Health Plan offered on the Marketplace.

By consenting to this agreement, I authorize the above-mentioned Agent to view and use the confidential information provided by me in writing, electronically, or by telephone only for the purposes of searching for an existing Marketplace application, completing an application for eligibility and enrollment in a Marketplace Qualified Health Plan, providing ongoing account maintenance and enrollment assistance for or responding to inquiries from the Marketplace regarding my Marketplace application.

I understand the following:

My personal information will not be used or shared for any purposes other than those shown above. The Agent will ensure that my Personally Identifiable Information (PII) is kept private and safe when collecting, storing, and using my PII for the stated purposes above.

I am 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 that meets or exceeds the affordability test for employee-only coverage.

Even if I am not eligible for Marketplace assistance due to meeting the employer affordability test, my family may be eligible for premium assistance for Marketplace health insurance coverage.

I agree that if I become eligible for other qualifying health coverage, I will 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 my back premium tax credit.

In order to obtain the premium tax credit paid on my behalf to reduce the cost of health coverage for myself or my dependents for the tax year:

1. I must file a federal income tax return for the tax year
2. If I'm married at the end of the tax year, I must file a joint income tax return with my spouse.
3. No one else will be able to claim me as a dependent on their federal income tax return.
4. I'll claim a personal exemption deduction on my federal income tax return for any individual listed on this application as my dependent who is enrolled in coverage through the 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:

1. It may impact my ability to get the premium tax credit.
2. 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 amount of income on my application, I may be eligible to get an 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.

The contents of this document do not have the force and effect of law and are not meant to bind the public in any way, unless specifically incorporated into a contract. This document is intended only to provide clarity to the public regarding existing requirements under the law. This model consent form will not supersede any State Agent of Record, Broker of Record, or other form required by a QHP issuer for purposes of making commission payments to the proper agent or broker for assisting a particular consumer.

I must tell the Marketplace if the information I listed on this application changes. I understand that a change in my information could affect my eligibility and the eligibility of members of my household.

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

I know that the information on this form will be used only to determine eligibility for health coverage, help pay for coverage if requested, and for lawful purposes of the Marketplace and programs that help pay for coverage.

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 my Agent beyond what is required on the application for eligibility and enrollment purposes. I understand that certain PII is required by the Marketplace to enroll in a plan, and if I choose not to provide such information, then the Agent will be unable to assist me or my authorized representative with enrolling in a Marketplace plan. I understand that my consent remains in effect until I revoke it, and I may revoke or modify my consent at any time by contacting the agent at the phone number listed below.

Name of Primary Writing Agent: Agent National Producer Number:

Phone Number: Email Address:

Name of Agency (if applicable): Agency National Producer Number:

Owner of Agency: Phone Number:

Email Address:

Name of Primary Household Contact and/or Authorized Representative:

Phone Number:

Email Address:

Signature:

Date:

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