MY ACA Health Care
Health Care Reform Advisors

ACA Pre-Enrollment Information

Application Date: ___________________________

Name: ____ ☐ Male ☐ Female

Phone number: ________________________ Email: _________________________________ DOB: _______________

Physical / Mailing address: ____

City: __________________________________ State: ________ Zip: ________________ County___________________

SSN: __________________________________ Married: Yes ☐ No ☐ / Pregnant: Yes ☐ No☐

Employer: ___________________________________City_______________State____Phone___________________

Anticipated Annual household Income MAGI (Combined sources):_______________________________________

Please list all dependents including DOB that are included on your Federal tax return. You must include SSN if you wish to have them covered with health insurance.

Spouse: ____ Include on policy: Yes No ☐ ☐

Spouse Employer Info: ____ / Income_____________________________

SSN: ____________________________ DOB: ______________ ☐Male ☐Female

Dependent: ____ Include on policy: Yes No ☐ ☐

SSN: ____________________________ DOB: ______________ ☐Male ☐Female

Dependent ____ Include on policy: Yes No ☐ ☐

SSN: ____________________________ DOB: ______________ ☐Male ☐Female

Dependent____ Include on policy: Yes ☐ No ☐

SSN: ____________________________ DOB: ______________ ☐Male ☐Female

Dependent ____ Include on policy: Yes No ☐ ☐

SSN: ____________________________ DOB: ______________ ☐Male ☐Female

Sign: ____ Submission Date: _____________________________

Market Place Account Information for Office Use Only

Subsidy Eligible: ☐ Yes ☐ No / Plan chosen: ____ Premium: ___________

Market Place User Name: ______________________________ Password: ___________________________________

Carrier User Name_____________________________________ Password___________________________________

Security questions and answers: 1.____
2.____
3.____

Did customer pay: ☐ Yes ☐ No

Attach Marketplace letter if applicable and confirmation of plan selection & premium. Attach receipt if customer paid.

AOR: 20812673

CONFIDENTIAL

CONSUMER CONSENT FORM

The Centers for Medicare & Medicaid Services (CMS) requires licensed sales agents to obtain consumer consent prior to accessing or updating the consumer's Marketplace information. This informs you of the functions and responsibilities of the licensed sales agent in the Marketplace and grants permission to the authorized licensed sales agent to conduct the following activities:

1. Search for an existing Marketplace application.
2. Complete an application for eligibility 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. Provide ongoing account maintenance and enrollment assistance, as necessary.
4. Respond to inquiries from the Marketplace regarding my Marketplace application.

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 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 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 one or more of the above.

I understand that the Agent will not use or share my personally identifiable information (PII) for any purposes other than those listed above. The Agent 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 my Agent 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 in writing.

____

First and Last Name of Primary Household Contact and/or Authorized Representative

Phone: __________________________ Email: ____

Signature: ____ Date: ______________________

____

First and Last Name of Primary Writing Agent Agent NPN

Phone: __________________________ Email: ____

____

Name Agency (if Applicable) Agency NPN

____

Agency Owner Name

Phone: ___________________________ Email: ____

Marketplace Application Privacy Notice

We are authorized to collect personally identifiable information (PII) from you by the Centers for Medicare & Medicaid Services (CMS). Any PII we collect is used to help you enroll in a Marketplace Qualified Health Plan (QHP) (and other related products you select, if applicable).

If you choose to give us PII, we may share this information with CMS and the insurer you select. CMS will maintain this information in a federal System of Records. PII is used or disclosed only under the following circumstances: to compare insurance plans based on costs, benefits, and other important features; to determine eligibility for health coverage and cost-sharing reductions through HealthCare.gov; to choose a plan; and to enroll in coverage.

Providing your PII is voluntary. If you choose not to provide us with the PII requested or not to respond to certain required HealthCare.gov questions, we will not be able to help you enroll in a QHP through the Marketplace. We recommend reaching out to the Marketplace Call Center directly at 1-800-318- 2596 (TTY: 1-855-889-4325) for further assistance in this scenario.

For more information, please review the CMS Privacy Notice on HealthCare.gov