Collect Consumer Authorization/Consent

Do you authorize me to serve as the licensed health insurance agent or broker for you and your entire household, if applicable, for purposes of enrollment in a Qualified Health Plan offered on the Federally Facilitated Marketplace?

By consenting to this agreement, you authorize me to view and use the confidential information provided by you in writing, electronically, or by telephone only for the purposes of one or more of the following:

- Searching for an existing Marketplace application.
- Completing 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.
- Providing ongoing account maintenance and enrollment assistance, as necessary; or

Responding to inquiries from the Marketplace regarding my Marketplace application.

Please confirm if the following statements are true by stating yes or no after each statement.

- If anyone on this application enrolls in Medicaid, I'm giving the Medicaid agency the right to pursue and get any 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.
- If a child on this application has a parent living outside of the home, I know I'll be asked to cooperate with the agency that collects medical support from an absent parent. If I think that cooperating to collect medical support will harm me or my children, I can tell the agency and I may not have to cooperate.
- I know that I must tell the program I'll be enrolled in if information I listed on this application changes. I know I can make changes in my Marketplace account or by calling the Marketplace Call Center at 1-800-318-2596 (TTY:1-855-889-4325). I know a change in my information could affect eligibility for member(s) of my household.
- I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting hhs.gov/ocr/office/file.
- I know that information on this form will be used only to determine eligibility for health coverage, help paying for coverage (if requested), and for lawful purposes of the Marketplace and programs that help pay for coverage.
- I'm signing this application under penalty of perjury, which means I've provided true answers to all of the questions to the best of my knowledge. I know I may be subject to penalties under federal law if I intentionally provide false information.
- At this time, I will review any additional attestations listed on your eligibility application that we have not already reviewed. [Read any additional attestations not already covered on the client's eligibility application.]
- Do you have any more questions regarding the attestations described in this call?
- By agreeing to these statements, you grant your permission to complete the eligibility application attestation required by the marketplace.

Thank you for completing the eligibility application attestation! I've documented this attestation and will add it to your file.