**CONSENT FOR BROKER ASSISTANCE**

**AS REQUIRED UNDER CMS-9899-F AMENDMENT OF 45 CFR § 155.220**

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| --- |
| Name of Primary Contact and/or Authorized Representative |
| Phone Number | Email |

**Household Contact Information**

**I give my permission to [Insert Agency Name], and/or their staff to provide the following services** on behalf of myself, and my entire household if applicable.

1. Search for an existing Marketplace application;
2. Completing an application for eligibility and enrollment in a marketplace Qualified Health Plan or government insurance affordability programs, such as Medicaid and CHIP or advance tax credits to help pay for Marketplace Premiums or enrollment in off-exchange insurance products as applicable;
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 [Insert Agency Name], and/or their staff will not share my personally identifiable information** **(PII)** and they will ensure that my PII is kept private and safe when collecting, storing, and using my information 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 my consent remains in effect until I revoke it, and I may revoke or modify my consent at any time.** I understand that requests must be made in writing, either by sending the request via certified mail to the address below or via email to [Email].

**Agency Contact Information**

[Name] | [Phone Number] | [Mailing Address]

**Agent Contact Information**

[Name] | [Email] | [NPN]

|  |  |  |
| --- | --- | --- |
| PRIMARY CONTACT SIGNATURE |  | DATE |



Disclosure: This consent form does not supersede any State or Federal Agent of Record, Broker of Record, or other form required by a QHP issuer.