Intake Form – Individual Health Insurance

Primary Applicant Date:

Date Of Birth SS#

Male ☐ Female ☐ Tobacco User? Yes ☐ No ☐ Pregnant? Yes ☐ No ☐

Address

City State Zip

Mailing, if different

City State Zip

Email Address Alternate Email

Home Cell Text? Yes ☐ No ☐

Employer Work Phone

Primary Care Physician

Preferred Hospital

Household INCOME Estimated Modified Adjusted Gross Income for the Current Year
Household = Tax filer + spouse + tax dependents

Applicant Spouse Dependent 1

Dependent 2 Dependent 3 Dependent 4

Spouse's Name Applying? Yes ☐ No ☐

Date Of Birth SS#:

Male ☐ Female ☐ Tobacco User? Yes ☐ No ☐ Pregnant? Yes ☐ No ☐

Employer Work Phone

Dependent Name 1 Applying? Yes ☐ No ☐

Date Of Birth SS#:

Male ☐ Female ☐ Tobacco User? Yes ☐ No ☐ Pregnant? Yes ☐ No ☐

Dependent Name 2 Applying? Yes☐No ☐

Date Of Birth SS#:

Male ☐ Female ☐ Tobacco User? Yes ☐ No ☐ Pregnant? Yes ☐ No ☐

Dependent Name 3 Applying? Yes☐No ☐

Date Of Birth SS#:

Male ☐ Female ☐ Tobacco User? Yes ☐ No ☐ Pregnant? Yes ☐ No ☐

Dependent Name 4 Applying? Yes☐No ☐

Date Of Birth SS#:

Male ☐ Female ☐ Tobacco User? Yes ☐ No ☐ Pregnant? Yes ☐ No ☐

Employment Health Coverage

Are you and/or your spouse offered health insurance coverage through an employer? Yes ☐ No ☐

If yes, complete the Employer Cover Tool form attached.

Does your and/or your spouse's employer offer an Individual Health Reimbursement Arrangement (ICHRA)? Yes ☐ No ☐

If yes, bring the notice that was given by your employer.

Does your and/or your spouse's employer offer a Qualified Small Employer Health Reimbursement Arrangement (QSEHRA) which reimburses a portion of the employee medical care cost?

Yes ☐ No ☐

AUTHORIZATION

I have voluntarily provided the information on this sheet to CHAMP, dba Customized Health And Medicare Plans to aid in the choice of individual health plan(s). I am pursing their advice for health plan(s) that will best service my needs. I agree to receive my personal, no cost, no obligation recommendation, and I further authorize a licensed sales agent to contact me by phone, text, email, or mail, if needed. This information, provided to Customized Health And Medicare Plans, is not to be used for any purpose other than for my health plan(s) selection. I understand I am not bound to accept their recommendation. By returning this form, I am authorizing a licensed agent from Customized Health And Medicare Plans to contact me.

Signature Date

POA Signature, if applicable Date

Updated: 2022-06-10

Privacy Notice Statement

This notice explains how CHAMP, dba Customized Health And Medicare Plans & Financial Services may collect, use, and share your information. Please read over it carefully and contact your agent if you have any questions.

Customized Health And Medicare Plans (also referred to herin as "we") has entered into an agreement with the Marketplace, under which we will comply with the Marketplace's privacy and security standards established by the U.S. Department of Health and Human Services and the Centers for Medicare & Medicaid Services.

We may collect, use, or disclose certain information about you, called Personally Identifiable Information ("PII"). This information can be used to identify you or trace your identity. Examples (not a complete list) of PII include your name, address, phone number, email, date and place of birth, Social Security Number, household income, marital status, race or ethnicity, credit/debit card numbers and bank account information.

We may disclose your PII to the Marketplace (or employees, agents or sub-contractors therof), certain federal or state agencies, a health insurance issuer offering a QHP that you have selected (or such issuer's emplyees, agents or subcontractors), or any individual who is duly and legally authorized to act on your behalf in connection with your PII. This includes any individuals acting under an appropriate power of attorney or appointment that complies with applicable state and federal law.

We may use and disclose PII if and to the extent reasonably necessary to assist you in comparing health insurance plans, helping with your application for insurance, correcting errors on your application, answering questions about your eligibilty, helping with filing appeals of eligibility determinations, reporting changes during the year, enrolling in qualified health plans ("QHPs") through the Federally Facilitated Marketplace ("FFM" or "Marketplace") or direct through the carrier, and/or applying for federal subsidies.

We will obtain your informed consent, which you may revoke at any time in writing, for any other uses or disclosures of PII. Our request to collect your PII for purposes of assisting you described in this notice is voluntary. If you choose not to provide the requested PII to us, then we may be unable to assist you with enrolling in a health insurance plan.

BIFS, LLC, is required to keep your information safe. We have developed privacy and security policies that must be followed to make sure your PII is protected.

DISCLAIMER

I have been provided a copy, read, and understand CHAMP, dba Customized Health And Medicare Plans Privacy Notice Statement regarding my Personally Identifiable Information (PII) and accept the terms of the Privacy Notice. I give permission for any licensed agent employed with BIFS, LLC, to 1) conduct a search for the consumer application using approved Classic Direct Enrollment/Enhanced Direct Enrollment websites in the Marketplace, 2) assist with completing an eligibility application, 3) assist with plan selection and enrollment, and 4) assist with ongoing account/enrollment maintenance. I have been made aware of compensation received by the agency because of my enrollment(s) as required by federal law. This consent is valid until I provide written revocation.

Applicant Name _____

Signature _____ Date _____

Updated: 2022-06-10

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Marketplace Application Attestations

• I am not eligible for health coverage from a job (including COBRA) or someone else's job.

• I am not an American Indian or Alaska Native.

• No one applying for coverage has a physical disability or mental health condition that limits their ability to work, attend school, or take care of their daily needs.

• No one applying for coverage needs help with daily activities (like dressing or using the bathroom) or lives in a medical facility or nursing home.

• No one applying for coverage was offered an individual coverage HRA (ICHRA)

• No one applying for coverage was offered a qualified small employer HRA (QSEHRA).

• I understand that I'm not eligible for a premium tax credit if I'm found eligible for other qualifying health coverage, like Medicaid, the Children's Health Insurance Program (CHIP), or a job-based health plan. I also understand that if I become eligible for other qualifying health coverage, I must 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 back my premium tax credit.

• If anyone on this application enrolls in Medicaid, I'm giving the Medicaid agency our rights 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 anyone on your application is enrolled in Marketplace coverage and is later found to have other qualifying health coverage (like Medicare, Medicaid, or CHIP), the Marketplace will automatically end their Marketplace plan coverage. This will help make sure that anyone who's found to have other qualifying coverage won't stay enrolled in Marketplace coverage and have to pay full cost.

I understand that because the premium tax credit will be paid on my behalf to reduce the cost of health coverage for myself and/or my dependents:

• I must file a federal income tax return for the current tax year.

• If I'm married at the end of the current tax year, I must file a joint income tax return with my spouse.

I also expect that:

• No one else will be able to claim me as a dependent on their 2022 federal income tax return.

• I'll claim a personal exemption deduction on my 2022 federal income tax return for any individual listed on this application as my dependent who is enrolled in coverage through this

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:

• I understand that it may impact my ability to get the premium tax credit.

• I also understand that when I file my 2022 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.

• I am willing to allow the Marketplace to use income data, including information from tax returns, for the next 5 years? Opt out anytime - https://www.healthcare.gov

• 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 know that I must tell the Health Insurance Marketplace® within 30 days if anything changes (and is different than) what I wrote on this application. I can visit HealthCare.gov or call 1-800-318-2596 to report any changes. I understand that a change in my information could affect my eligibility as well as eligibility for member(s) 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.

Name

Signature Date

POA Signature, if applicable Date

Employer Coverage Tool

Use this worksheet to help you gather information about employers that offer traditional health coverage to anyone on your Marketplace application. Complete one form for each employer that offers coverage. You'll need this information to complete the application, even if no one enrolls in coverage through their job (or the job of another person, like a spouse or parent).

Don't use this form if someone works for a business that offers:

- Help paying for a health plan
- To reimburse medical expenses through a Health Reimbursement Arrangement (HRA).

Look at the notice from the employer for the information you need to complete your Marketplace application. Visit **HealthCare.gov/job-based-help** to learn more.

Employee information

Fill in for the **employee** who's offered job-based health coverage.

1. Employee name (First, Middle, Last)	2. Employee Social Security Number (SSN)
	___ - ___ - ____

3. List the first and last names of each person in the employee's household and tell us if they could get health coverage through the employer named in box 4 below, even if they're not currently enrolled. Only list household members who the employee plans to include on their federal income tax return.

Name	Eligible for health coverage through this employer?
	◯ Yes ◯ No
	◯ Yes ◯ No
	◯ Yes ◯ No
	◯ Yes ◯ No

Employer information

You can ask the **employer** to fill out these items.

4. Employer name		
5. Person or department we can contact for information about any coverage offered		
6. Employer address (the Marketplace may send notices to this address)		
7. City	8. State	9. ZIP code

10. Employer contact phone number	11. Employer contact email address	12. Employer Identification Number (EIN)
(___) ___ - ____		___ - _____

Tell us about the health coverage offered by this employer.

13. Do the plans offered by the employer meet the minimum value standard? A health plan meets the minimum value standard if it pays at least 60% of the total cost of medical services for a standard population and offers substantial coverage of hospital and doctor services. Most job-based plans meet the minimum value standard.

◯ **YES** (Go to question 14.) ◯ **NO** (STOP and return this form to employee.)

◯ The employer offers plans that meet the minimum value standard to only the employee.

14. How much would the employee pay for themselves for the lowest-cost plan that meets the minimum value standard? Don't include family plans.

a. Employee would pay this premium: **$**

b. Employee would pay this amount: ◯ Weekly ◯ Every 2 weeks ◯ Twice a month ◯ Monthly ◯ Quarterly ◯ Yearly

15. **If other household members are listed for question 3:** How much would the employee pay for the lowest-cost plan that covers the employee and the household members listed in question 3? If the employer offers wellness programs, enter the premium that the employee would pay if the employee got the maximum discount for any tobacco cessation programs and didn't get any other discounts based on wellness programs.

a. Employee would pay this premium: **$**

b. Employee would pay this amount: ◯ Weekly ◯ Every 2 weeks ◯ Twice a month ◯ Monthly ◯ Quarterly ◯ Yearly

You have the right to get Marketplace information in an accessible format, like large print, Braille, or audio.
You also have the right to file a complaint if you feel you've been discriminated against.

Visit **CMS.gov/about-cms/agency-information/aboutwebsite/cmsnondiscriminationnotice**,
or call the Marketplace Call Center at 1-800-318-2596 for more information. TTY users can call 1-855-889-4325.

Health Insurance Marketplace
CMS Product No. 12164
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HealthCare.gov