CONSENT FOR BROKER ASSISTANCE

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

Household Contact Information

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

I give my permission to CHAMP, dba Customized Health And Medicare Plans, 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 CHAMP, dba Customized Health And Medicare Plans, 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 info@bakerinstx.com

Agency Contact Information

Tabatha Ainsworth
1005 S Jackson St
Jacksonville TX 75766
903-586-5051
tabatha@bakerinstx.com

Agent Contact Information

Select Agent
1005 S Jackson St
Jacksonville TX 75766
903-586-5051

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.

NABIP
Shaping the future of healthcare

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 _____