



3502 Paesanos Pkwy, Ste 102
San Antonio, TX 78231
210-738-3537

Consumer Authorization Form

I, _____ [insert name of primary household contact], give my permission to _____ [insert name of the person or entity who has the consumer's consent], NPN: _____, 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 following: 1. Searching for an existing Marketplace application; 2. 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; 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 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 by _____ [insert method to revoke consent].

I understand that:

- 1. I don't have to provide _____ with any information that I do not want to provide. However, the help _____ provides is based only on the information provide, and if the information given is inaccurate or incomplete, _____ May not be able to offer all the help that is available for my situation.
- 2. _____ Should ask me to provide only the minimum amount of my PII that is necessary to help me.
- 3. _____ Must make sure that my PII is kept private and secure when creating, collecting, disclosing, Accessing, maintaining, storing, and/or using my PII. _____ Must follow the privacy and information security standards that apply to them.
- 4. If I give my contact information when signing this form, my general consent includes permission for _____ to follow up with me about applying for or enrolling into coverage after my first meeting with them.
- 5. Once I have signed this authorization form, I can expect _____ to help me without asking me to sign another authorization form for another 365 days.

Tax Attestation:

Attestation 1: Having other qualifying health coverage may disqualify me from receiving a premium tax credit. It is my responsibility to inform the marketplace about my eligibility for such coverage to avoid repayment issues.
Attestation 2: I acknowledge that the premium tax credit will be applied to reduce the cost of health coverage for me and/or my dependents. Filing a federal income tax return for 2023, including a joint return if married, is required. I can claim a personal exemption deduction for each dependent enrolled in Marketplace coverage with their premium partially or fully paid by advance payments of the tax credit.
Attestation 3: I understand that any changes to the provided information may affect my eligibility for the premium tax credit. The IRS will crossreference the income reported on my tax return with the information on my application. Discrepancies may result in adjustments to my tax obligations, including potential repayment or additional taxes.

Consumer or Authorized Representative Signature and Signature Date:

Signature

Signature Date

If you are the authorized representative, please sign above and print below:

Representative's Name

Your Relationship to the Consumer