In-Person Assister Guide/Outreach Enrollment Assister Guide State Partnership Marketplace Authorization and Consent Form

Organization Name and Address:
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Organization Phone Number :
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Individual IPA/OEA Name and License Number:
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I, (*print name*) ___________________________, give my permission, or
_____________________ [Insert name of authorized representative], my legal or Marketplace authorized representative acting on my behalf, permission to create, collect, disclose, access, maintain, use, and/or store my personally identifiable information and/or the personally identifiable information of my authorized representative, to perform the following duties of a In-Person Assister Guide /Outreach Enrollment Assister Guide:

- Inform me and/or my authorized representative about the full range of Marketplace health coverage options and insurance affordability programs for which I'm eligible;
- Help me complete my application for health coverage in a Qualified Health Plan (QHP) through the Marketplace and for insurance affordability programs;
- Help me enroll in a QHP or in an insurance affordability program.

I understand that I may revoke this authorization at any time and will notify 1st Choice Healthcare if I choose to revoke my authorization.

I understand that 1st Choice Healthcare has the following responsibilities and will perform the following functions:

- Will inform me and/or my authorized representative about the full range of Marketplace health coverage options and insurance affordability programs for which I'm eligible.
- Will help me apply for health coverage in a QHP through the Marketplace and for insurance affordability programs, and will help me enroll in a QHP or in an insurance affordability program.
- Will inform me of any possible conflicts of interest they might have.
- Will follow privacy and information security standards when creating, collecting, disclosing, accessing, maintaining, storing, and/or using my personally identifiable information and/or the personally identifiable information of my authorized representative. Information about these standards will be provided.
- Can't choose a health insurance plan for me and is required to act in my best interest.
- Aren't expected or required to maintain or store any of my personal information and/or the personal information of my authorized representative, other than this authorization form, which will be stored according to privacy and information security standards.

- I and/or my authorized representative don’t have to give more information than I and/or my authorized representative choose to provide.
- The assistance provided is based only on the information I and/or my authorized representative provide, and if the information provided is inaccurate or incomplete the IPA/OEA may not be able to provide all the assistance available for my situation.
- If the IPA/OEA is unable to assist me and/or my authorized representative, they will refer me or my authorized representative to another person who can help me.
- There will be no charge for me and/or my authorized representative for any assistance provided.

Please sign and date the form:

Signature of Consumer/Consumer’s Legal or Marketplace Authorized Representative (please circle a status to indicate whether you’re the consumer or the consumer’s representative)

Date ________________________