Text

Description automatically generated

**Account Creation and Remote Application Assistance Authorization**

This form gives [Health Center Name] and its Certified Application Counselors the authority to create an account on Healthcare.gov and submit a health insurance application on your behalf. You are agreeing to this authorization because you do not have access to a computer and/or you cannot meet in person with an assister.

Please read and complete this form carefully.

**Consumer’s Information:**

First and Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address (optional): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/town:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Privacy Warning**

You are not legally required to provide this information and there are no negative consequences if you do not complete this form, though your Certified Application Counselor will be unable to create an account and apply for health coverage on your behalf.

* [Health Center Name] must keep this Authorization for ten (10) years.
* You may cancel your consent at any time, by notifying [Health Center Name] in writing. You can end this authorization by contacting your Certified Application Counselor.

**Account Creation and Remote Application Assistance Authorization**

By completing and signing this form, you are authorizing [Health Center Name] and your Certified Application Counselor to:

* Create an account for you on Healthcare.gov. Creating an account is the first step to determine your eligibility for benefits and enrolling in health coverage. To create a new account, Healthcare.gov must collect enough information to verify your identity and determine your eligibility. This information is private, and your Certified Application Counselor will safeguard it.
* Collect enough information to apply for and determine the eligibility of other household members who are on your application. Their information is private, and your Certified Application Counselor will safeguard it.
* Act on matters related to this application, including signing your application on your behalf and enrolling you and other household members in a qualified health plan that you select.

**Your Responsibilities Following Enrollment**

Following selection and enrollment into a health plan, you remain responsible for:

* Meeting all applicable deadlines for enrolling in coverage, such as paying any required premiums; and
* Responding to any communications from Healthcare.gov or your health insurance plan.

**[Health Center Name] Responsibilities to Protect your Privacy**

[Health Center Name] agrees to:

* Only use your private information for the purpose of completing the healthcare.gov application or as otherwise allowed by state and federal law.
* Safeguard the data from unauthorized access, use, modification, destruction, theft or disclosure.
* Follows all the privacy warnings and terms and conditions of Healthcare.gov [https://www.healthcare.gov/individual-privacy-act-statement/] and the privacy policies of [Health Center Name]

Please provide the following information about the assister you wish to authorize:

Certified Application Counselor’s first and last name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Certified Application Counselor’s Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Organization: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Certified Application Counselor’s ID Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Consumer’s Signature Today’s Date