

HealthSherpa Enrollee Assistance Program

Standard Consent Form

I, _____ [name of primary applicant], give my permission to _____ [name of assisting agent] and HealthSherpa or its designated agent representatives, Morgan Blein, Achleay Page, Larissa Shontelle Brown, Carmen Lockhart, or George Kalogeropoulos (collectively, the "Agent") 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 phone only for one or more of the following:

- Searching for an existing Marketplace application
- 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
- Providing ongoing account maintenance and enrollment assistance, as necessary
- Responding to inquiries from the Marketplace regarding my 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.

Primary Applicant Signature: _____ **Date:** _____

Eligibility Application Review:

I, _____ [name of primary applicant], have reviewed the eligibility application as completed by _____ [name of assisting agent] and I confirm its accuracy. _____ [name of assisting agent] has reviewed all attestations at the end of the application, and I agree and understand these terms to submit my application to the Marketplace.

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 emailing _____ [assisting agent's email address] and customer_support@healthsherpa.com. *(Please sign on next page)*

Phone number:

(855) 772-2663

Email address:

customer_support@healthsherpa.com

Name of assisting agent:

Assisting agent NPN:

Phone number:

Email address:

Name of primary household contact:

Authorized representative (if applicable):

Phone number:

Email address:

Primary applicant signature:

Date: