Consent Form for Marketplace Agents and Brokers

I, _____ , give my permission to my personal Agent _____ and to OCI Insurance & Financial Services and its principal Charles Olson 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 or any State Based Exchange Platform. 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 my Agent will not use or share my personally identifiable information (PII) for any purposes other than those listed above. This agreement ensures that my Agent will keep my PII 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 providing my Agent and/or OCI with written correspondence. I understand that by signing this document, I am revoking any consent forms signed prior to this one.

I understand that I agree to receive text messaging from the Agent listed as listed on this form. I confirm that I understand I will have the option to opt-out of receiving text messages at any time.

By signing this form, I agree to **The Marketplace Privacy Statement and Agreements** shown below.

Privacy and the use of your information: The Marketplace will keep your information private as required by law. Your answers on this form will only be used to determine eligibility for health coverage or help paying for coverage. The Marketplace will check your answers using the information in their databases and the databases of other federal agencies. If the information does not match, the Marketplace may ask you to send them proof. The Marketplace will not ask

any questions about your medical history. Household members who do not want coverage will not be asked questions about citizenship or immigration status.

As part of the application process, the Marketplace may need to retrieve your information from the Internal Revenue Service (IRS), Social Security, the Department of Homeland Security (DHS), and/or a consumer reporting agency. They will need this information to check your eligibility for coverage and with help paying for coverage if you want it and to give you the best service possible. The Marketplace may also verify your information at a later date to ensure your information is up to date and matches their records. Should something change on their end they will notify you accordingly.

Renewal of Coverage

To make it easier to determine my eligibility for help paying for coverage in future years, I agree to allow the Marketplace to use my income data, including information from tax returns, for the next 5 years. The Marketplace will send me a notice, let me make any changes, and I can opt out at any time.

Tax Attestation

I understand that I am not eligible for a premium tax credit if I am found eligible for other qualifying health coverage, like Medicaid, 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 my Agent at OCI or the Marketplace to end my Marketplace coverage and premium tax credit. If I do not, the person who files taxes in my household may need to pay back my premium tax credit.

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 2024 tax year.
- If I am married at the end of 2024, I must file a joint income tax return with my spouse.

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 2024 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.

Sign and Submit Application

- I know that I must tell the program I'll be enrolled in if the information I listed on my health insurance application changes. I know I can make changes in my Marketplace

account by calling my Agent at OCI or by calling the Marketplace Call Center at 1-800-318-2596 (TTY: 1-855-889-4325). I know a change in my information could affect eligibility for member(s) of my household.

- If anyone on your application is enrolled in Marketplace coverage and is later found to have other qualifying health coverage (like Medicare, Medicaid, or Children's Health Insurance Program (CHIP)), the Marketplace will automatically end their Marketplace plan coverage. This will help make sure that anyone who is found to have other qualifying coverage won't stay enrolled in Marketplace coverage and have to pay full cost. I agree to allow the Marketplace to end the Marketplace coverage of the people on my application in this situation.
- I agree to provide true answers to all questions for my application to the best of my knowledge. I know I may be subject to penalties under federal law if I intentionally provide false information.
- I allow my Agent to electronically sign my policy for me.

I acknowledge that I have read this document and agree to all things contained in it.

Name of the Primary Writing Agent: _____

Agent National Producer Number: _____

Phone Number: _____

Email Address: _____

Name of Agency: OCI Insurance & Financial Services

Agency National Producer Number: 7438843

Owner of Agency: Charles Olson

Owner of Agency NPN: 229298

Phone Number: 402-330-8700

Email Address: clientconnect@ociservices.com

Name of Primary Household Contact and/or Authorized Representative: _____

Phone Number: _____

Email Address: _____

Client Signature: _____

Date: _____

PRA DISCLOSURE: According to the Paperwork Reduction Act or 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1438, expiration date is xx/xx/20xx. The time required to complete this information collection is estimated to take up to 0.17 hours per year, including the time to review instructions, gather the information needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. ****CMS Disclosure**** Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact Brian Gubin at Brian.Gubin@cms.hhs.gov.