

Consent Form

For help enrolling in the Missouri Health Insurance Marketplace

CAC Name and Number: _____

Words used in this form:

- **CAC or Certified Application Counselor** – A person who is trained to help people apply for insurance through the Marketplace
- **PII or Personally Identifiable Information** – Information needed to fill out the health insurance application online, such as your name, address, telephone number, and Social Security number
- **Tax credits and cost-sharing reductions** – Money the government pays to help lower the cost of your health insurance and health care
- **Legal or Marketplace authorized representative** – A person you approve to apply for insurance for you
- **Eligible** – This means you meet certain requirements that allow you to sign up for a program

I, _____, or my authorized representative, _____, give my permission to the CAC to help me with my application on the Health Insurance Marketplace. To help me, the CAC may need to see and use my PII or my authorized representative's PII. The CAC will **only** use my PII to do their work. This includes:

- Telling me about all of my health insurance options on the Marketplace and other health programs I am eligible for, such as Medicaid and CHIP, in a fair and truthful way.
- Telling me about all programs that can help me lower my costs (tax credits or cost-sharing reductions) I might be eligible for.
- Helping me complete my application for health insurance on the Marketplace in these ways:
 - Helping me set up an email account, if needed, so I can apply on the Marketplace. The CAC will not keep my password or username.
 - Helping me sign up for a health insurance plan on the Marketplace.
- Helping me with any complaints or questions I may have about my health insurance application or eligibility.

The CAC may not use my PII for any other reason. I understand that:

- The CAC will do his or her best to tell me about all of my health insurance options and financial help on the Marketplace.
- The CAC will not choose a health insurance plan for me.
- The CAC will make sure that my PII is kept private and safe when collecting, storing, and using my PII and my authorized representative's PII to apply on the Marketplace.
- The CAC will only keep this consent form. The CAC will not keep any of my PII or that of my authorized representative after we meet. If I would like the CAC to set up another time to help with my application, I allow the CAC to keep my name and phone number or other contact information I provide to set up that meeting.

_____ Yes. It is okay to keep my name and contact information so the CAC can set another time for us to meet about my application (please initial).



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- If the CAC cannot help me with my application – for example, because of a language barrier or because the CAC does not know the answer – the CAC will tell me about other resources that can help me.
- I do not have to give any information to the CAC. This means I do not have to share personal information about myself or my health.
- The CAC gives help based on the information that I or my authorized representative give. If the information I give is not true or complete, the CAC may not be able to help in all the ways that he or she can.
- The CAC cannot charge a fee or accept gifts for giving help.
- The CAC will give me a copy of this consent form today if I would like.
- I can have an authorized representative sign this form. If I do this, I understand that the representative may need to share their PII for my application.

I can cancel my consent in writing at any time. I will let the CAC know I chose to cancel my consent. I understand that I only need to sign this consent form one time.

CAC signature: _____

I am (check one):

- Consumer Consumer’s Legal or Marketplace Authorized Representative
- I would like the CAC to enter the application information for me and my family.

Signature of Consumer or Authorized Rep Date Phone number (optional)

I, _____, or my authorized representative, _____, confirm that the information I will provide on my Health Insurance Marketplace application will be true to the best of my knowledge. I also agree that the CAC or Navigator helping me has explained that I have a legal responsibility to report the required information for myself and all family members who are applying.

Signature of Consumer or Authorized Rep Date

Want to learn more about health insurance?

- No**, I do not want the CAC to contact me with future information about health insurance.
- Yes**, I want the CAC to contact me with future information about health insurance.

I want to get information by (check all that apply and provide your contact information):

Mail: _____ Email: _____

Phone: _____ Text (message and data rates may apply): _____

