

CONSENT FOR BROKER ASSISTANCE

AS REQUIRED UNDER CMS-9899-F AMENDMENT OF 45 CFR § 155.220

Name of Primary Contact and/or Authorized Representative	
<input type="text"/>	
Phone Number	Email
<input type="text"/>	<input type="text"/>

Household Contact Information

I give my permission to Amber Insurance Agency, and/or their staff to provide the following services on behalf of myself, and my entire household if applicable.

1. Search for an existing Marketplace application;
2. Completing an application for eligibility and enrollment in a marketplace Qualified Health Plan or government insurance affordability programs, such as Medicaid and CHIP or advance tax credits to help pay for Marketplace Premiums or enrollment in off-exchange insurance products as applicable;
3. Providing ongoing account maintenance and enrollment assistance, as necessary; or
4. Responding to inquiries from the Marketplace regarding my Marketplace application.

I understand that Amber Insurance Agency, and/or their staff will not share my personally identifiable information (PII) and they will ensure that my PII is kept private and safe when collecting, storing, and using my information 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 my consent remains in effect until I revoke it, and I may revoke or modify my consent at any time. I understand that requests must be made in writing, either by sending the request via certified mail to the address below or via email to Daveamber@ymail.com.

Agency Contact Information

David Amber 402-261-7300 8055 O Street Suite S108 Lincoln, NE 68510

Agent Contact Information

David Amber Daveamber@ymail.com 3191081

Primary Contact Signature

Date

Disclosure: This consent form does not supersede any State or Federal Agent of Record, Broker of Record, or other form required by a QHP issuer.

