Marketplace Application Review Consent & Compliance Form

I, **(First Name)** **(Last Name)**

give permission to: Maheshkumar (Mike) Modha with The Mothe 21 LLC., DBA: Modha Financial Group.

- 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 and/or a member of their Agency 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:

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; or
- Responding to inquiries from the Marketplace regarding my Marketplace application.
- I understand that the Agent or Agency will not use or share my personally identifiable information (PII) for any purposes other than those listed above. The Agent and Agency will ensure that my PII is kept private and safe when collecting, storing, and using my PII for the stated purposes above.

I confirm and attest to have reviewed my Marketplace eligibility application information for accuracy.

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 my Agent.

I understand that this document is used to remain in compliance with CMS guidelines.

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 emailing my Agent.

I understand that this document is used to remain in compliance with CMS guidelines.

- **Consumer Email:** * **Phone:** *
- I hereby provide consent to the Agent and / Or Agency to Contact me for information concerning my health insurance needs via: *
- **Email:** ☐ **OR** **Text:** ☐ **OR** **Phone:** ☐
- **Income estimate given to Agent:** * **$**
- **Date of Authorization:** * **Signature:** *

- **By submitting this form, I agree that this document was signed by the person giving permission on this form, the information contained herein is correct and is intended to be used by the Assisting Agent / Agency as confirmation that I have read and understood the above document**.

MODHA $ FINANCIAL GROUP

ObamaCare HELP LINE 813-476-1540

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Email: MikeModha@MSN.com

Major Medical / Short Term Health Insurance Form for Single OR Couple

Step 1 Self Details

Name (as on SS Card): _____

Home Address: _____ City: _____

County: _____ State: _____ ZIP Code: _____ Married: ☐ Yes ☐ No

Mobile/Cell: _____ Home phone number: _____

DOB (mm/dd/yyyy): ___ /____ /_____ Age: ____ Social Security Number: _____-____-_____

E-Mail: _____ Height: _____ Weight: _____ Gender: ☐ M ☐ F

US citizen? ☐ Yes ☐ No If Yes, Certificate # _____ Alien A # _____

Green Card? ☐ Yes ☐ No Alien A #_____ Green Card Expiration Date: _____

Tobacco? ☐ Yes ☐ No Are you pregnant? ☐Yes ☐No ☐N/A Are you applying? ☐ Yes ☐ No

Step 2 Spouse Details

Name (as on SS Card): _____ Gender: ☐ Male ☐ Female

Relationship with you? _____ Height: _____ Weight: _____

DOB (mm/dd/yyyy): ___ /____ / _____ Age: _____ Social Security Number: _____-____-_____

E-Mail: _____ Tobacco: ☐ Yes ☐ No

US citizen? ☐ Yes ☐ No If Yes, Certificate # _____ Alien A # _____

Green Card? ☐ Yes ☐ No Alien A #_____ Green Card Expiration Date: _____

Tobacco? ☐ Yes ☐ No Are you pregnant? ☐Yes ☐No ☐N/A Applying health Insurance? ☐ Yes ☐ No

Do you have a physical, mental or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.) or live in a medical facility or nursing home? ☐ Yes ☐ No

Are you or your family currently enrolled in health coverage with HealthCare.gov? ☐ Yes ☐ No

Step 3 Job and Income Information of Self and Spouse

Self: ☐ Employed ☐ Self-Employed ☐ Not Employed

Total Expected self-Income in 2025: $ _____

Employer Name: _____ Employer Phone Number: _____

Spouse: ☐ Employed ☐ Self-Employed ☐ Not Employed

Total Expected Spouse Income in 2025: $ _____

Employer Name: _____ Employer Phone Number: _____

Total Expected Adjusted Gross Household Income together in 2025: $ _____

Step 4 Primary Care Provider (Doctor) Details

Name: _____ Phone: _____

Address: _____ City: _____ State: ____ ZIP Code: _____

Office phone number: _____ Fax number: _____

Specialist (Doctor) Details

Name: _____ Phone: _____

Address: _____ City: _____ State: ___ ZIP Code: _____

Office phone number: _____ Fax number: _____

Medicines (If you are taking)

Medicine Name	Dosage/Day	Strength (Mg/ML)