2024 ACA Health Plan DATE: ____

N.C. Parekh, 200 M L K Jr Blvd, Warner Robins, GA 31088 (478) 952 0067 or (478) 213 3512
fAX; 478-449-5799 ncp.wrga@gmail.com

Parekh Insurance

Client name: _____ Client Phone number: _____

Client Address: _____City:_____ Zip Code: _____County: _____

Client Email: _____ Agent/Source Referral: _____

INCOME: Applicant __$_____Company..... Ph.....

Spouse.....$..... Company..... Ph.....

2024 POVERTY GUIDELINES
If household income falls in the ranges below, based on family size, they MAY qualify for a subsidy.

Persons in household	Poverty guideline 100% -	150 -	400%
1	15060	22590	60240
2	20440	30660	81760
3	25820	38730	103280
4	31200	46800	124800
5	36580	54870	146320
6	41960	62940	167840

On Exchange: (MAY Qualify for subsidy if Income level 100 - 400 %)
ACA compliant plans with Essential Health Benefits
Narrow Networks

Off Exchange:(IF ABOVE may NOT qualify for premium subsidy)
ACA compliant plans with Essential Health Benefits
Narrow and Broad Networks available

IMPORTANT
Agent information for enrollment through healthcare.gov
NPN: **6985786**
User Name: **ncparekh**
Agent Name: Narendra C Parekh

Note: Desired ACA plan (healthcare.gov) to follow-up.

TO BE INSURED: **MEDICAL _____ DENTAL _____**

Name _____DOB _____ SSN: _____ Tobacco User ___

Spouse _____ DOB _____ SSN: _____ Tobacco User ___

Child (ren) Name _____ DOB _____ SSN: _____ Tobacco User ___

Name _____ DOB _____ SSN: _____ Tobacco User ___

Name _____ DOB _____ SSN: _____ Tobacco User ___

Name _____ DOB _____ SSN: _____ Tobacco User ___

Other Family Dependents :

Name …… DOB……SSN…… Tobacco……

Name …… DOB……SSN……Tobacco……

ALIEN STATUS : ● Citizen or Other Status ***Please provide document numbers Front & Back (or copies)***

****** BY COMPLETING this FORM you agree PRIVACY ACT STATEMENT attached .**

Please provide desired choices of Providers or Medications required in the Network Plan you desire****

Agent Enrollment & Review Consent Forms for the Marketplace will be required at each stage ****

Signature…… Date 10/21/2024 ……

GEORGIA ACCESS

Consumer Consent Form for Georgia Access Agents

Consumer Name: _____ **Date:** _____

Agent/Agency Name: _____ **NPN:** _____

I give permission to the above mentioned agent/agency to serve as the health insurance agent for myself and my entire household if applicable, for enrollment in a Qualified Health Plan offered on the Georgia State-based Exchange (Georgia Access). By consenting to this agreement, I authorize the above-mentioned agent/agency to view and use the confidential information provided by me in writing, electronically, or by telephone only for the purpose of one or more of the following:

1. I give permission to access my information for the purpose of helping me complete an application for eligibility and enrollment in a Qualified Health Plan or other insurance affordability programs, such as Medicaid and PeachCare for Kids® (CHIP) or advance tax credits to help pay for insurance premiums.

_____ _____

Primary Household Contact/Authorized Representative **Date**

2. I agree that I have been informed and agree with all the disclaimers included in my exchange application.

_____ _____

Primary Household Contact/Authorized Representative **Date**

3. I understand the plan(s) I am being enrolled in and agree that I wish to be enrolled in that plan; I understand that I may cancel the delegation at any time either within the Georgia Access portal, a certified partner portal, or by calling the Georgia Access contact center at 1-888-687-1503.

_____ _____

Primary Household Contact/Authorized Representative **Date**

4. I give the agent only ☐ **OR** agent and any member of their agency ☐ permission to assist me in maintaining my information and changing my plans in the future without requiring consent. I understand that I am not obligated to provide this consent, but if I do not, I will need to document a new consent every time I require future assistance from my agent.

_____ _____

Primary Household Contact/Authorized Representative **Date**

Enrollment consent form

I, _____ [name of primary household contact], give my permission to Narendra C Parekh [name of the person or entity who has the consumer's consent] ("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 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 confirm that I have reviewed my completed application and that all information is accurate.

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 contacting my Agent or by revoking it through my HealthSherpa dashboard.

Primary Writing Agent

Name of primary writing Agent: Narendra C Parekh

Agent National Producer Number: 6985786

Phone number: 478-952-0067

Email address: ncp.wrga@gmail.com

Agency (if applicable)

Name of Agency (if applicable): _____

Agency National Producer Number: _____

Owner of Agency: _____

Phone number: _____

Email address: _____

Primary applicant

Name of primary household contact: _____

Authorized representative (if applicable): _____

Phone number: _____

Email address: _____

Primary contact signature: _____

Date: _____

Individual Privacy Act Statement

Permission for information submitted

By submitting this application, you represent that you have permission from all of the people whose information is on the application to both submit their information to the Marketplace, and receive any communications about their eligibility and enrollment.

Privacy Act Statement – effective 10/1/2013

We are authorized to collect the information on this form and any supporting documentation, including social security numbers, under the Patient Protection and Affordable Care Act (Public Law No. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law No. 111-152), and the Social Security Act.

We need the information provided about you and the other individuals listed on this form to determine eligibility for: (1) enrollment in a qualified health plan through the Federal Health Insurance Marketplace, (2) insurance affordability programs (such as Medicaid, CHIP, advance payment of the premium tax credits, and cost sharing reductions), and (3) certifications of exemption from the individual responsibility requirement. As part of that process, we will verify the information provided on the form, communicate with you or your authorized representative, and eventually provide the information to the health plan you select so that they can enroll any eligible individuals in a qualified health plan or insurance affordability program. We will also use the information provided as part of the ongoing operation of the Marketplace, including activities such as verifying continued eligibility for all programs, processing appeals, reporting on and managing the insurance affordability programs for eligible individuals, performing oversight and quality control activities, combatting fraud, and responding to any concerns about the security or confidentiality of the information.

While providing the requested information (including social security numbers) is voluntary, failing to provide it may delay or prevent your ability to obtain health coverage through the Marketplace, advance payment of the premium tax credits, cost sharing reductions, or an exemption from the shared responsibility payment. If you don't have an exemption from the shared responsibility payment and you don't maintain qualifying health coverage for three months or longer during the year, you may be subject to a penalty. If you don't provide correct information on this form or knowingly and willfully provide false or fraudulent information, you may be subject to a penalty and other law enforcement action.

In order to verify and process applications, determine eligibility, and operate the Marketplace, we will need to share selected information that we receive outside of CMS, including to:

1. Other federal agencies, (such as the Internal Revenue Service, Social Security Administration and Department of Homeland Security), state agencies (such as Medicaid or CHIP) or local government agencies. We may use the information you provide in computer matching programs with any of these groups to make eligibility determinations, to verify continued eligibility for enrollment in a qualified health plan or Federal benefit programs, or to process appeals of eligibility determinations. Information provided by applicants won't be used for immigration enforcement purposes;
2. Other verification sources including consumer reporting agencies;
3. Employers identified on applications for eligibility determinations;
4. Applicants/enrollees, and authorized representatives of applicants/enrollees;
5. Agents, Brokers, and issuers of Qualified Health Plans, as applicable, who are certified by CMS who assist applicants/enrollees;
6. CMS contractors engaged to perform a function for the Marketplace; and
7. Anyone else as required by law or allowed under the Privacy Act System of Records Notice associated with this collection (CMS Health Insurance Exchanges System (HIX), CMS System No. 09-70-0560, as amended, 78 Federal Register, 8538, March 6, 2013, and 78 Federal Register, 32256, May 29, 2013).

Identity Verification

To protect your privacy, you will need to complete Identity Verification successfully before requesting higher account privileges. You are providing consent to Experian, an external identity verification provider, to access your personal information to conduct ID Verification on behalf of CMS. Below are a few items to keep in mind.

- Ensure that you have entered your legal name, current home address, primary phone number, date of birth, and email address correctly. We will collect personal information only to verify your identity with Experian.
- Identity Verification involves Experian using information from your consumer report profile to help confirm your identity. As a result, you may see an entry called a "soft inquiry" on your Experian consumer report. Soft inquiries are visible only to you, will never be presented to third parties, and do not affect your credit score. The soft inquiry will be titled "CMS Proofing Services" and will be removed from your Experian consumer report after 25 months.
- You may need to have access to your personal and consumer report information, as the Experian application will pose questions to you, based on data in their files.

This statement provides the notice required by the Privacy Act of 1974 (5 U.S.C. § 552a(e)(3)). You can learn more about how we handle your information at: https://www.healthcare.gov/how-we-use-your-data.