CMS Consent Form for Marketplace Agents and Brokers

I, _____ primary household contact, give my permission to Maheshkumar Modha of The Mother 21 LLC, D/B/A 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 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 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 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 _____.

Name of Primary Writing Agent: Maheshkumar Modha, Agent National Producer Number: 7537134
Phone Number: 813-476-1540 Email Address: mikemodha@msn.com

Name of Agency: The Mother 21 LLC. Agency National Producer Number: 17698943
Owner of Agency: Maheshkumar Modha & Shilpaben Modha. Phone Number: 813-476-1540
Email Address: mike@ModhaGRP.com

Name of Primary Household Contact and/or Authorized Representative: _____
Phone Number: _____ Email Address: _____

Signature: _____ Date: _____

MODHA $ FINANCIAL GROUP

ObamaCare
HELP LINE 813-476-1540
Email: MikeModha@MSN.com

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Individual / Family Major Medical - Short Term Health Insurance Form

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 Household Income in 2023: $ _____ Total Expected Income in 2024: $ _____

Employer Name: _____ Employer Phone Number: _____

Spouse: ☐ Employed ☐ Self-Employed ☐ Not Employed

Total Household Income in 2023: $ _____ Total Expected Income in 2024: $ _____

Employer Name: _____ Employer Phone Number: _____

Checklist for Documents Required for Application

Income: ☐ 1040 Tax Return ☐ W-2 ☐ Pay Stub ☐ SSN Statements ☐ Unemployment Benefits Letter

Immigration Status: US Passport copy ☐ Yes ☐ No Naturalization Certificate ☐ Yes ☐ No Green Card copy: ☐ Yes ☐ No Immigration visa copy or approval letter ☐ Yes ☐ No

Dependent 1 Details

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

Relationship with you? _____ Tobacco: ☐ Yes ☐ No Height: _____ Weight: _____

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

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

Dependent 2 Details

Name (as on SS Card): _____ Gender: ☐ Male ☐ Female
Relationship with you? _____ Tobacco: ☐ Yes ☐ No Height: _____ Weight: _____
DOB (mm/dd/yyyy): ____ /____ /_____ Age: _____ Social Security Number: _____-____-_____
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

Dependent 3 Details

Name (as on SS Card): _____ Gender: ☐ Male ☐ Female
Relationship with you? _____ Tobacco: ☐ Yes ☐ No Height: _____ Weight: _____
DOB (mm/dd/yyyy): ____ /____ /_____ Age: _____ Social Security Number: _____-____-_____
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

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)

_____

_____

Remarks: _____

_____