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: ___________________________

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 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: ______________________

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)

____

____