# CMS Consent Form for Marketplace Agents and Brokers

I, ________________________________________ primary household contact, give my permission to Nick Jawad of American Insurance & Financial Advisors, LLC 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: Nick Jawad __________ Agent National Producer Number: 706143

Phone Number: 813-340-1275 Email Address: nickjawad@aifausa.com

Name of Agency: American Insurance & Financial Advisors, LLC _________

Owner of Agency : Nick Jawad & Rebecca Jawad ____________ Phone Number: 813-340-1275

Email Address: nickjawad@aifausa.com Agency National Producer Number: 18623175

Name of Primary Household Contact and/or Authorized Representative: ______________________________

Phone Number: ___________________ Email Address: ________________________________________

Signature: ________________________________________ Date: ____________________________

OBAMACARE

Email: nickjawad@aifausa.com

# 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:** __________________________________________________________________________________

_______________________________________________________________________________________________