



# 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: \_\_\_\_\_



Email: nickjawad@aifausa.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)**

\_\_\_\_\_  
\_\_\_\_\_