Eligibility Application Attestation
Marketplace Agents and Brokers

I, ________________________________ (name of primary household contact) have reviewed the eligibility application details with my agent and attest to the following:

- I'm signing this application under penalty of perjury, which means I've provided true answers to all the questions on this form to the best of my knowledge. I know that I may be subject to penalties under federal law if I intentionally provide false or untrue information.
- I know that I must tell the Health Insurance Marketplace® within 30 days if anything changes (and is different than) what I wrote on this application. I can visit HealthCare.gov or call 1-800-318-2596 to report any changes. I understand that a change in my information could affect my eligibility as well as eligibility for member(s) of my household.
- I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting HHS.gov/civil-rights/filing-a-complaint.
- I know that information on this form will be used only to determine eligibility for health coverage, help paying for coverage (if requested), and for lawful purposes of the Marketplace and programs that help pay for coverage.
- I have been provided an explanation of the attestations at the end of the eligibility application.

Eligibility Application Attestations (select all that apply)

The attestations below may vary depending on the eligibility determinations of each consumer.

- If a child on this application has a parent living outside of the home, I know I'll be asked to cooperate with the agency that collects medical support from an absent parent. If I think that cooperating to collect medical support will harm me or my children, I can tell the agency and I may not have to cooperate.
- If anyone on this application enrolls in Medicaid, I'm giving the Medicaid agency the right to pursue and get any money from other health insurance, legal settlements, or other third parties. I'm also giving the Medicaid agency rights to pursue and get medical support from a spouse or parent.
- Other:

Consumer or Authorized Representative Signature:____________________________

Signature Date: ________________

Print (Authorized Representative's name):__________________________________

Representative's relationship to consumer:_________________________________

Name of Authorized Licensed Sales Agent:__________________________________