ROANITA JENKINS
INSURANCE AGENCY LLC

2024 Health Insurance Marketplace Application Checklist

Roanita Jenkins, Certified Healthcare Reform Specialist®
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Agent NPN#: 7138487

Please read and sign below

I authorize Roanita Jenkins, to serve as the agent for myself and my entire household ,if applicable, for purposes of enrollment in a qualified health plan on the Federally Facilitated Marketplace. By consenting to this agreement, I authorize the agent to view and use the confidential information provided by me in writing, electronically or by telephone only for the purposes of:

1. Assist in setting up a Marketplace and account and completing an application for eligibility & enrollment in a health plan or advance tax credits to help pay for Marketplace premiums.
2. Providing on going account maintenance and enrollment assistance as necessary; or
3. Responding to inquiries from the Marketplace regarding my Marketplace application.
4. Searching for an existing 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 my consent at any time by contacting the agent at 318-651-0047, by contacting healthcare.gov at 1-800-318-2596 or by contacting my insurance carrier at the number listed on the back of my member ID card.

X_____

(Applicant/Primary Household Contact Signature) (Date)

Roanita Jenkins , 7138487

(Agent's Signature, NPN Number) (Date)

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1. Applicant's Full Name: _____(*The way that it appears on your social security card).*

2. Applicant's Marital Status: (Circle One) Single Married

Divorced Widowed

*****If you are married, you must include your spouse's income even if he/she does not need coverage. You are also required to file a joint tax return for 2024 when receiving a subsidy.*

X Sign here if married:_____

3. Applicant's Physical Address:

_____

_____

_____

4. Applicant's Mailing Address, *(if different from Physical Address):*

_____

_____

_____

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5. Applicant's Phone Number:

Cell: _____Home: _____

6. Applicant's DOB: _____

7. Applicant's Social Security Number: _____

8. Applicant's Email:_____
(Please be sure you can log into your email account or receive emails on your mobile device at the time of your appointment).

9. Parish you reside in: _____

_____

10. Number of people in household: *(This should be the same number of people you plan to list on your 2024 tax return as your dependent(s).* _____

11. Who is applying for coverage? _____

12. Spouse's Full Name: _____

DOB_____SS#:_____

Male or Female (Circle One)

13. Childs Full Name: _____

DOB_____SS#:_____

Relationship to Applicant: _____

Male or Female (Circle One)

14. Childs Full Name: _____

DOB_____SS#:_____

Relationship to Applicant:_____

Male or Female (Circle One)

15. Childs Full Name: _____

DOB_____SS#:_____

Relationship to applicant: _____

Male or Female (Circle One)

16. Please list your doctors /hospitals here:

_____
_____
_____
_____
_____
_____

17. Total Household Modified Adjusted Gross Income Expected for 2024:
If your dependents have income, there income MUST be included. (DO NOT include SSI or child support).

Applicant 1:

_____
_____
_____
_____

Applicant 2:

_____
_____
_____
_____

Applicant 3.

_____
_____
_____
_____

Applicant 4:

_____
_____
_____
_____

Total expected household income for 2024: _____

18. Employer Name and Telephone Number: *(include both past and present employers for 2024):*
_____
_____

19. Verification of Household Income: *(List information provided or amounts provided by Applicant) (Agent will complete)*

Method used to verify income: W2_____ Payroll Stub_____ Income Tax_____ Other_____

_____
_____
_____
_____
_____

20. Marketplace Security Questions: (Answers are case sensitive)

What is your favorite radio station? _____

What is your favorite food? _____

List a significant date in your life? _____

What city was your mother born in? _____

What was your childhood nickname? _____

Acknowledgements:

21. *(Read and initial)* _____I acknowledge that I MUST file a 2024 tax return and that my Advanced Premium Tax Credit given is based upon the information I provided to the agent. I confirm that all information listed on the application and submitted to the Health Insurance Market Place, is true to the best of my knowledge. I also understand income changes must be immediately reported to healthcare.gov. and that if my income changes, I could owe money back to the Federal government for the advanced premium tax credit/subsidy.

22. *(Read and initial, if applicable)* _____I confirm that health insurance coverage ***IS NOT*** offered to me through my job or my spouse's job if married.

23. *(Read and initial, if applicable)* _____*I confirm that health insurance coverage **IS** offered to me and my dependents by my employer/job, but it is unaffordable. Applicant MUST have employer/job complete employer coverage tool form for application to be processed.) Agent can provide the form if needed.)*

24. (Circle one) Did you recently lose or are losing health insurance coverage? YES - NO. If yes, please put the date you lost or are losing coverage. *(Must provide documentation)*

_____

25. *(Read and initial)* _____I confirm that no one applying for coverage has any Parts of MEDICARE, to include Medicare Part A, Part B, Parts A&B, Part C or Part D.

26. *(Read and initial* _____I confirm that I know that I must make my payment BEFORE my effective date of coverage, or my coverage will be cancelled as if it were never effective by the marketplace. I understand that plan documents will only be sent to me after paying my first premium.

27. *(Read and initial)* _____
I confirm that if I am married and I receive a Tax Credit, that I MUST file a JOINT 2024 income tax return with my spouse and must also include their income on the Marketplace application for coverage even if they do not need/want coverage.

28. *(Read and initial)* _____I confirm that I **DO** or DO NOT *(circle one)* have an individual or employer group sponsored health reimbursement account.

29. *(Read and initial)* _____Do you have any type of Individual Health Reimbursement Account (HRA)? Yes – No? *(circle one)*

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Important notice to members regarding marketplace providers. *(Read and Sign below)*

If you are enrolling into a marketplace plan for 2024 and I did not confirm at the time of your appointment if a doctor was in network for the plan you enrolled in, please do the following **BEFORE** going to see providers.

Call the number on the back of your insurance card and let the customer service representative look up your plan and confirm if a doctor is in your plans network. All marketplace plans have different provider networks for the various plans. It is always to your benefit to use doctors in the plans network to avoid additional costs and balance billing.

Please do not rely on calling your doctor's office for this information. Often, they don't realize you are asking about a marketplace plan. Please get the information from the insurance company and not the doctor's office.

What you need to do:

1. Call your plan. Be sure to have your member ID card.
2. Advise the representative that you would like to get provider information regarding your plan.
3. Let them know you are calling to inquire about a doctor being "in network" for your plan.

If you go out of network on the marketplace plans, in most cases the insurance carrier will not pay the claim, and you could be balance billed the entire amount of the bill. * Lastly, always open any mail or emails you receive from the marketplace.

X Applicants Signature: _____Date:_____

Benefits Disclaimer:

I acknowledge that the agent explained to me that my plan has a $_____ in network deductible which means I will have to pay $_____ before my plan will start paying anything towards the in-network benefits per my plan choice. My PCP Copay is $_____ or is subject to my deductible of $_____. My Specialist Copay is $_____ or is subject to my deductible of $_____.

X Applicants Signature: _____Date:_____

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FOR AGENT USE ONLY:

2024 Application Summary Sheet

Please review and sign where indicated.

*****Follow up required by applicant:** (Agent can upload your documents electronically to your Marketplace Account, *(recommended)* or you can mail your documents to the Marketplace. (See Eligibility Determination Notice the Marketplace will mail to you.) Not submitting the requested documents by the date requested will/may cause you to lose your subsidy and be billed for the full cost of the plan.

_____

_____

_____

_____

_____

_____

.***Your first payment must be made to the insurance carrier *BEFORE* your effective date, or your coverage will be cancelled.

Application ID #:_____ Individual or Family Coverage?

Insurance Plans Reviewed: _____ Blue Cross Blue Shield of Louisiana
_____United Health Care
_____Other: _____

Amount of Advanced Premium Tax Credit: $_____per month

Full Cost of Plan: $_____ Applicant's Monthly Cost: _____

Was Cost Sharing Reductions granted to Applicant? YES or NO _____

Plan Chosen: _____Effective Date: _____

Your Marketplace Account LOG ON Information *Open 24 hours a day; 7 days a week.*
Website: www.healthcare.gov Telephone Number: 1-800-318-2596

30. **Marketplace Username AND Password**: *(Both are case sensitive). Please do not share your log on information. You can change this information at any time. Just be sure you are always able to log into your marketplace account for agent to be able to assist you.*

Username: Password: