**APPENDIX E**

**Model Certified Application Counselor (CAC) Authorization Form**

**In Federally-Facilitated or State Partnership Marketplaces**

CAC Designated Organization Name and Address:

CAC Designated Organization Phone Number and Email:

Individual CAC Name and Certification Number:

I, , give my permission, or

[Insert name of authorized representative], my legal or Marketplace authorized representative acting on my behalf (“authorized representative”), gives permission to

[Names]1 to create, collect, disclose, access, maintain, use, and/or store my personally identifiable information (PII) and/or the PII of my authorized representative, to perform the following duties of a CAC Designated Organization or CAC2:

 Inform me and/or my authorized representative about the full range of Marketplace health coverage options and insurance affordability programs for which I’m eligible;

 Help me complete my application for health coverage in a Qualified Health Plan (QHP) through the Marketplace and for insurance affordability programs;

 Help me enroll in a QHP or in an insurance affordability program.

I understand that I may revoke this authorization at any time and will notify

 [Names] if I choose to revoke my authorization.

I understand that

 [Names] have the following responsibilities and will perform the following functions:

  [Names] will inform me and/or my authorized representative about the full range of Marketplace health coverage options and insurance affordability programs for which I’m eligible, will help me apply for health coverage in a QHP through the Marketplace and for insurance affordability programs, and will help me enroll in a QHP or in an insurance affordability program.

  [Names]

will inform me of any possible conflicts of interest they might have.

  [Names]

can’t choose a health insurance plan for me.

1 NOTE TO CAC DESIGNATED ORGANIZATION AND INDIVIDUAL CAC: Each time [Names] appears in this Authorization Form, the Name of the CAC Designated Organization *and* the name of the individual staff/volunteer CAC should be inserted on the blank line in front of [Names].

2 These duties are set forth in 45 CFR §155.225.

  [Names]

is required to act in my best interest.

  [Names] will follow privacy and information security standards when creating, collecting, disclosing, accessing, maintaining, storing, and/or using my PII and/or the PII of my authorized representative. Information about these standards will be provided.

  [Names] aren’t expected or required to maintain or store any of my PII and/or the PII of my authorized representative, other than this authorization form, but if

 [Names] do maintain or store my PII, they will follow privacy and information security standards.

 I and/or my authorized representative do not need to provide

 [Names] contact information, unless I want [Names] to follow-up with me on applying for or enrolling into coverage. My consent to follow- up is given by providing my phone number and/or e-mail address below.

  [Names]

 I and/or my authorized representative don’t have to give

 [Names] more information than I and/or my authorized representative choose to provide.

 The assistance [Names] provide is based only on the information I and/or my authorized representative provide, and if the information provided is inaccurate or incomplete,

 [Names] may not be able to provide all the assistance available for my situation.

 If [Names] are unable to assist me and/or my authorized representative, they will refer me or my authorized representative to another person who can help me (a Navigator or other Marketplace-authorized assistance personnel), or to the Exchange call center.

  [Names]

won’t charge me and/or my authorized representative a fee for any assistance provided.

**Please sign and date the form:**

Signature of Consumer/Consumer’s Legal or Marketplace Authorized Representative (please circle a status to indicate whether you’re the consumer or the consumer’s representative)

Date

Phone Number and E-Mail Address for Follow-Up (Optional)

**PLEASE NOTE**: Consumers may sign this authorization form themselves, or choose to have a legal or

Marketplace Authorized Representative complete this form.