# 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 CAC[2]:

- 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.

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[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.