CONSUMER CONSENT FORM

In–Person Assister (IPA) Guide Name: _____ License Number_____

IPA Guide Phone Number (____) _____ E-mail:_____

PLEASE NOTE: ***Consumers may sign this consent form themselves, or may choose to have a legal guardian, personal representative, or other delegated representative sign it. Personal or other delegated representatives must be able to present appropriate legal documentation of this role.***

I, _____, give my permission, or _____, my legal or Marketplace authorized representative acting on my behalf ("authorized representative"), gives his/her permission to the above mentioned IPA Guide to inform me and/or my authorized representative about my health coverage options in the Marketplace to help me apply for and enroll in health coverage through the Marketplace if I choose to do so, and/or to help with a grievance, complaint, or question about my health plan, coverage, or a determination under such a plan or coverage. I understand that in giving this consent that the above mentioned IPA Guide will need to see or use some of my personally identifiable information (PII) in order to provide this assistance.

I understand that:

- The above mentioned IPA Guide will help me to the best of his or her ability by telling me about the full range of Qualified Health Plan (QHP) options and insurance affordability programs for which I may be eligible and assist me with completing my application for enrollment and enrolling in a QHP through the Marketplace or other insurance affordability programs; and will help me with grievances, complaints, or questions about my health plan, coverage, or a determination under such a plan or coverage, if I want that help.
- The above mentioned IPA Guide can't choose a health insurance plan for me.
- The above mentioned IPA Guide will inform me of any possible conflict of interest they may have.
- The above mentioned IPA Guide will make sure that my PII is kept private and secure when creating, collecting, disclosing, accessing, maintaining, storing, and/or using my PII and/or the PII of my authorized representative. My PII will only be used for the purposes of assisting with Marketplace decisions and eligibility determinations, grievances, and complaints and will not be used to discriminate against me.
- The above mentioned IPA Guide should not maintain or store any of my PII and/or the PII of my authorized representative, other than this consent form, as a result of carrying out the duties of an IPA Guide. The above will make sure that any stored PII is kept private and secure.
- I and/or my authorized representative don't have to provide the above mentioned IPA Guide with more information than I and/or my authorized representative choose to provide.
- The above mentioned IPA Guide will not charge me a fee for any help provided.
- My PII will be maintained and stored by the Arkansas Insurance Department for a period of six (6) years. My PII will not be disclosed, altered or destroyed in any unauthorized manner. If I wish to access, update or dispute the accuracy of my PII, or wish to report non-adherence of any of these standards, I may contact the Arkansas Insurance Department at the number or address below.
- All federal and state privacy standards have been followed to protect my PII, and that the standards will be monitored and reviewed for compliance throughout the year. If I have questions about specific privacy measures, I may contact the Arkansas Insurance Department at the number or address below.
- I may revoke my consent at any time by contacting the Arkansas Insurance Department at the address below.

Please sign and date the form:

_____ **Date**_____

Consumer/Consumer's Legal or Marketplace Authorized Representative Signature

(Please also circle one of these to show if you are the consumer or the consumer's representative.)

Phone Number and E-mail Address for Follow-up (Optional)

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Please mail this completed form to: **Arkansas Insurance Department, Attn: Arkansas Health Connector Division**
1200 West Third Street
Little Rock, AR 72201