ACA Application and Subsidy Attestation

Every individual in the household 18 years and older who is requesting coverage through the ACA is required to complete this Attestation form.

I, _____, attest that I am _____ years old and my date of birth is _____.

I attest that I make $_____ per year.

I confirm this to be factually true on this _____ day of _____ (month), _____ (year), and any false information may result in being charged with perjury under federal law.

_____ _____

Signature of Applicant Date

Assistance with Completing this Application

You can choose an authorized representative. You can give a trusted person permission to talk about this application with you, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative". If you ever need to change your authorized representative, contact the Marketplace. If you're a legally appointed representative for someone on this application, submit proof with the application.

1. Name of Authorized Representative (first name, last name)

James Rudy Smith

2. Address

1108 Spring Road

3. City 4. State 5. Zip Code

Lugoff **SC** **29078**

6. Phone Number

803-461-8945

7. Organization Name

R. Smith & Associates

By signing, you allow this person to sign your application, get official information about this application, and act for you on all future matters related to this application.

_____ _____

Your Signature **Date**

Affordable Care Act --Privacy Notice Statement

This notice explains how *R. Smith & Associates* and its Affiliated Brokers may collect, use, and share your information. Please read it carefully and contact Rudy Smith, R. Smith & Associates, if you have any questions.

Why did you give me this notice?	I am/We are legally required to give you this notice by applicable law and our agreement with the federal government. I/We respect your personal information and want you to fully understand how I/we may use and share your information.
What information will you ask me to give to you?	I/We must collect certain information about you, called **Personally Identifiable Information** (PII) in order to help you complete your application for health insurance. PII is information that can be used to identify or trace your identity. These are a few examples of PII: (This is not a complete list) Date of birth, telephone number, name, address, social security number, household income, marital status, race or ethnicity, credit or debit numbers
How will you use my information?	I/we will use only the information that we need to help you obtain health insurance through the Federally Facilitated Exchange (FFE) and to provide Authorized Functions approved by the FFE, or other services permitted under applicable law. These are a few of the authorized functions that we may conduct. This is not a complete list: - Helping with your application for insurance - Answering questions about your eligibility - Helping to enroll you in a qualified health plan - Helping with filing Appeals of eligibility determinations - Correcting of errors
Will you share my information with anyone?	I/We may only share your information as described in this notice. I/We may share your information with certain Federal and/or State agencies, the health issuer that you select, or subcontractors that help me/us provide services to you.
What happens if I don't share my information with you?	If you do not want to share your information, you may not be able to enroll in a health insurance plan.
Will you keep my information safe?	YES. I am/we are required to keep your information safe. I/We have developed privacy and security policies that I/we must follow to ensure that we protect your PII.
Signatures	I/We must get your permission to share your information for any other purpose that is not already described in this notice. _____ _____ ACA Applicant's Signature Date

Agent of Record

I, _____, name **James Rudy Smith, Agent ID 548-041**, as my authorized representative and name him as my Agent of Record. This is to be effective from the date my coverage begins until the date my coverage ends, unless written notification is received from me. This includes any modifications that I need to make, including income changes, etc.

Signature _____

Date _____