Consent Form for Marketplace Agents/Brokers

I hereby give my permission to Thomas Buonanduci, Agent (Alternative Benefit Solutions, LLC) to serve as the health insurance Agent or broker for myself and my entire household if applicable, for purposes of enrollment in a Qualified Health Plan offered on the Federally Facilitated Marketplace. By consenting to this agreement, I authorize the above-mentioned Agent to view and use the confidential information provided by me in writing, electronically, or by phone only for one or more of the following:

- Searching for an existing Marketplace application
- Completing an application for enrollment in a Marketplace Qualified Health Plan (or Medicaid/CHIP) including eligibility (if applicable) for advance tax credits to help pay for Marketplace premiums
- Providing ongoing account maintenance and enrollment assistance, as necessary
- Responding to inquiries from the Marketplace regarding my 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 or modify my consent at any time by contacting my Agent.

Name of Primary Writing Agent:	**Thomas Buonanduci**
Agent Producer #:	**3539529**
Phone #:	(603) 622-5700
Email Address:	HealthPlanSavings@comcast.net
Name of Agency:	Alternative Benefit Solutions, LLC
Agency National Producer #:	8338598
Owner of Agency:	Thomas Buonanduci
Phone #:	(603) 622-5700
Email address: (same as above)	

Name of Primary Household Contact* _____

Mobile Phone # _____

(e)Signature _____

Date: _____

*or Authorized Representative