

**WA Health Benefit
Exchange
Consumer Consent Form**



The Washington Health Benefit Exchange requires producers to document the scope of the marketing appointment to ensure consumer understanding of what will be discussed between the producer and the consumer (or their authorized representative). All information on this form is confidential and should be completed by each person or their authorized representative.

Please initial beside the type of product(s) you want to discuss.

1. Qualified Health Plan _____ 2. Qualified Dental Plan _____ 3. Washington Apple Health _____

By signing this form, you agree to a meeting with a sales agent to discuss the types of products you initialed above. Please note, the person who will discuss the products is either employed or contracted with an insurance carrier. *Signing this form does NOT obligate you to enroll in a plan, affect your current enrollment, or enroll you in a Qualified Health Plan, Dental Plan or Washington Apple Health.*

Consumer or Authorized Representative Signature and Date:

Signature: _____ Date: _____

If you are the authorized representative, please sign above and print below:

Representative's name: _____

Your relationship to the consumer: _____

To be completed by producer:

Producer Name: Archana Iyer Sunil Producer's phone: 425-615-1268

Producer Address: 21002 NE 44th St Sammamish WA 98074

Consumer's name: _____

Consumer's address: _____

Initial Method of Contact: (indicate here if the consumer was a walk-in, direct mail, email, phone call, prior client, etc.) _____

Plan(s) presented during this meeting: ACA Plans Marketplace

Date of appointment: _____