Benefit Planning Solutions Inc.

Alexander Katsef
Licensed Insurance Planner

MyBenefitPlaning.com
215-760-6171 267-760-3586 Fax: 215-240-7342
Alex@mybenefitplaning.com akatsef@aol.com

APPLICANT INFORMATION

Existing Client: Yes No | Who do you have an appointment with? Alexander Katsef ☑ ☐ | MP Authorization: ☐ ☐ End Date_____

1 *Name: | *Date of Birth: | *S/S# | Gender: M F | *Coverage through a job, Medicare or Medicaid Yes No

*Address: | *Apt / Unit: | *City: | *State: PA | *Zip:

* Mobile Phone: | * E-mail Address: | *DL# | * Citizen ☐ I-551 ☐ I-766 ☐ I-797 ☐ ASYLUM ☐ | Smoker: Yes No

EMPLOYMENT INFORMATION

*Current Employer: | Employer Address:

*Phone: | Fax: | E-mail:

*Occupation: | * W2 1099 Unemployment NONE *(circle one)* | *Annual Income:

SPOUSE INFORMATION

2 *Name: | * Date of Birth: | * S/S# | *Gender: M F | * Coverage through a job, Medicare or Medicaid Yes No

*Mobile Phone: | *E-mail Address: | *DL# | Citizen ☐ I-551 ☐ I-766 ☐ I-797 ☐ ASYLUM ☐ | Smoker: Yes No

TOTAL HOUSEHOLD INCOME $$

SPOUSE EMPLOYMENT INFORMATION

*Current Employer: | Employer Address:

*Phone: | Fax: | E-mail:

*Occupation: | * W2 1099 Unemployment NONE *(circle one)* | *Annual Income:

DEPENDANT'S INFORMATION

3	* Dependant 1:	* DOB	* S/S#	* M F	* Coverage through a job, Medicaid, or CHIP Yes No	Citizen ☐ I-551 ☐ I-766 ☐ I-797 ☐ ASYLUM ☐
4	* Dependant 2:	* DOB	* S/S#	* M F	* Coverage through a job, Medicaid, or CHIP Yes No	Citizen ☐ I-551 ☐ I-766 ☐ I-797 ☐ ASYLUM ☐
5	* Dependant 3:	* DOB	* S/S#	* M F	* Coverage through a job, Medicaid, or CHIP Yes No	Citizen ☐ I-551 ☐ I-766 ☐ I-797 ☐ ASYLUM ☐
6	* Dependant 4:	* DOB	* S/S#	* M F	* Coverage through a job, Medicaid, or CHIP Yes No	Citizen ☐ I-551 ☐ I-766 ☐ I-797 ☐ ASYLUM ☐

QUALIFYING EVENT FOR THE SPECIAL ENROLLMENT

☐ Moving to a new home in a new ZIP code or county ☐ Moving to the U.S. from a foreign country or United States territory ☐ Gain of eligible immigration status. ☐ Birth of a child
☐ Leaving incarceration ☐ Losing job-based coverage ☐ Losing eligibility for Medicaid or CHIP ☐ Changes that make you no longer eligible for Medicaid or the Children's Health Insurance Program (CHIP)
☐ Being determined ineligible for Medicaid or CHIP. You applied for Medicaid or CHIP during the Marketplace Open Enrollment Period and your state Medicaid or CHIP agency determined that you weren't eligible for Medicaid or CHIP after Open Enrollment ended. You may qualify for a Special Enrollment Period regardless of whether you applied through: Your state Medicaid directly or Health Insurance Marketplace.

AKNOWLEGEMENT

I certify that I have received a copy of the Privacy Policy and that I have entered all information in the Health Insurance Marketplace truthfully and accurately. I attest that I have created a dedicated email address to use for all correspondence to and from the Health Insurance Marketplace and/or AJ Insurance Partners or its affiliates. The information supplied on this application and any signed addendum is accurate and complete to the best of my knowledge. No material information has been written or omitted on any person applying. I understand that if my signature and date do not appear and/or my answers are incomplete, that application will be either rejected or returned for completion.

Applicant Signature: | Date: | Who is on Policy: 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐

Qualifying Event for the **Special Enrollment** | PCP

Proof of the Residency: US Passport ☐ | Citizenship Cert. ☐ | Natur. Cert. ☐ | Green Card," (I-551) ☐ | Empl. Auth. Card (I-766) ☐ | LETTER I-797 ☐ | I-94 ☐ | VISA ☐ | Driver Licence ☐

Proof of the Income: 1040-Tax return ☐ | W2 Statement ☐ | 1099 Statement ☐ | Paystub ☐ | Unemployment ☐ | Rental Property ☐ | Winnings ☐ | Other ☐

Plan Name:	**FOR OFFICE USE ONLY**			***Application ID:***
MEMBER ID:	***BIN:***	***PNC:***	***Payment: $*** ***Full Premium: $***	***Starting Date: 01-01-2024***
Bill To Account #	***User Name:***			***Password:***

Please bring the following documents to your appointment: 1. Income documents such as a resent pay stub, your most resent 1099/W2 Forms or Tax Returns. 2. Proof of citizenship or immigration such as US Passport, Certificate of Citizenship, Certificate of Naturalization, Green Card or Work Authorization card.

Privacy Act Statement

The Patient Protection and Affordable Care Act (Public Law No. 111 -148), as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law No. 111 -152), and the Social Security Act authorizes Pennie to collect the information on your application and any necessary supporting documentation, including social security numbers, to determine whether you and the listed people on your application are eligible for health coverage or help paying for health coverage.

Pennie needs the information you provided us on your application about yourself and the other people included in your household to determine eligibility for: (1) enrollment in a qualified health plan through Pennie, (2) insurance affordability programs (such as Medicaid, APTC, and CSR), and (3) certifications of exemption from the individual responsibility requirement. As part of that process, Pennie will electronically verify the information you provided on your application; communicate with you or your authori zed representative, if you choose to have one; and eventually provide the information to the health plan you select so that they can enroll any eligible individuals in a qualified health plan or insurance affordability program. Pennie will also use the information in the future to conduct activities such as verifying your continued eligibility for health coverage or help paying for health coverage, processing appeals, reporting on and managing the insurance affordability programs for eligible individuals, p erforming oversight and quality control activities, combatting fraud, and responding to any concerns about the security or confidentiality of the information.

While providing the information we ask you on the application (including social security numbers and documentation of your immigration status) is voluntary, failing to provide the information may delay or prevent you from obtaining health coverage or help paying for health coverage through Pennie. If you don't provide correct information on this form or knowingly and willfully provide false or fraudulent information, you may be subject to a penalty and other law enforcement action.

In order determine if you and the people on your application are eligible for health coverage, or help paying for health c overage, and to operate Pennie, we will electronically check the information you provided us on your application with the information in other electronic data sources. Such data sources include:

- We will need to share your information with other federal and state government agencies, such as the Internal Revenue Service (IRS), the Social Security Administration (SSA), and the United
- States Department of Homeland Security (DHS), the United States Department of Health and
- Human Services, and the Pennsylvania D epartment of Human Services;
- Other electronic data sources, including customer reporting agencies;
- Employers identified on applications for eligibility determinations;
- Applicants/enrollees;
- The authorized representatives of applicants/enrollees;
- Agents, Brokers, and issuers of Qualified Health Plans, as applicable, who are certified by
- Pennie to assist applicants/enrollees and who have been authorized to help applicant/enrollees;
- Contractors we engage to help run Pennie; and

Anyone else as required by law.

- This statement provides the notice required by the Privacy Act of 1974 (5 U.S.C. § 552a(e)(4)).

Record of the customer's consent:

Print Name_____Signature_____Date_____