2026 open enrollment

Hochron Insurance Agency, LLC (Ilisa Barretta)

317 Harrington Avenue Closter, NJ 07624 Phone # (201) 768-90896

Consent Form for Health insurance Coverage placement / enrollment

I, _____[insert name of primary household contact], give my permission to Ilisa Barretta NPN 7416626 of Hochron Insurance Agency, 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 GetCoveredNJ 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 telephone only for the purposes of one or more of the following:

1. **Searching for an existing Marketplace application.**
2. **Completing an application for eligibility and enrollment in a Marketplace Qualified Health Plan or other government insurance affordability programs, such as Medicaid and CHIP or advance tax credits to help.**
3. **Pay for Marketplace premiums.**
4. **Providing ongoing account maintenance and enrollment assistance, as necessary; or**
5. **Responding to inquiries from the Marketplace regarding my Marketplace application**.

☒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 sending an email from email address on my account, expressing that I would like to revoke my consent to use my information and assist me further with securing, or shopping for health insurance. send to Ibarretta@hochroninsurance.com

☒I understand that Ilisa Barretta of Hochron Insurance agency will add me to her client roster and that I may receive informational contact emails throughout the year, usually 1 per month and around renewal time to advise me of important information, product offerings of the agency or open enrollment information. I will have full control over if I wish to unsubscribe from any correspondence, and should I unsubscribe, I will also not receive the agency's informational emails regarding health insurance open enrollment. I give agent/broker permission to email/Text me regarding insurance matters at the listed email

☒I acknowledge the following Note to customer: For your protection You should not provide any personal identifiable information or payment or send copies of forms or applications though unencrypted email. GETCOVEREDNJ.gov is the official site for the marketplace program or carrier site for direct purchases.

☒I acknowledge that the broker is paid a monthly commission for the products sold: Horizon omnia $17.50 omnia per month Horizon advantage $9.75 per m month, AmeriHealth Advantage products $20 per month per policy. AmeriHealth local value $6 per application per month. Oscar & UHC $20per member per month.

Email:
Primary household contact or Authorized representative
Cell phone:
Print name _____
Signature_____Date:

This form must be returned to IBarretta@hochroninsurance.com

Vs9/2024