Eligibility Application Confirmation Documentation (EACD)

I, _____, confirm that I have reviewed the Marketplace Eligibility Application information and confirm it to be accurate.

Furthermore, I acknowledge that I have been explained the attestations included at the end of the eligibility application. I acknowledge that these attestations are referenced on page two of this document.

Zip Code_____ Number of members in tax household _____

Estimated Household Income $ _____

Do you qualify for an affordable employer based plan? Yes ☐ No ☐

Do you qualify for Medicare or Medicaid? Yes ☐ No ☐

The Marketplace Eligibility Application information was completed with assistance provided by the writing agent identified below.

Name of Primary Writing Agent:	
Agent National Producer Number:	
Phone Number:	
Email Address:	

Name of Primary Household Contact and/or Authorized Representative:	
Date of Review:	
Phone Number:	
Email Address:	
Signature:	
Signature Date:	

Explanation of Attestations

- I'm signing this application under penalty of perjury, which means I've provided true answers to all of the questions to the best of my knowledge. I know I may be subject to penalties under federal law if I intentionally provide false information.

- I know that I must tell the Health Insurance Marketplace within 30 days if the information I listed on this application changes. I know I can make changes in my Marketplace account or by calling Marketplace Call Center at 1-800-318-2596 (TTY: 1-855-889-4325). I understand that a change in my information could affect my eligibility as well as eligibility for member(s) of my household.

- I understand that if anyone on my application is enrolled in Marketplace coverage and is later found to have other qualifying health coverage (like Medicare, Medicaid, or Children's Health Insurance Program (CHIP)), the Marketplace will automatically end their Marketplace plan coverage. This will help make sure that anyone who's found to have other qualifying coverage won't stay enrolled in Marketplace coverage and have to pay full cost.

- I know that under federal law, discrimination is not permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity or disability. I can file a complaint of discrimination by visiting hhs.gov/ocr/office/file.

- I know that information on the application will be used only to determine my eligibility for health coverage, help paying for coverage (if requested), and for lawful purposes of the Marketplace and programs that help pay for coverage.

- I understand that I'm not eligible for a premium tax credit if I'm found eligible for other qualifying health coverage, like Medicaid, Children's Health Insurance Program (CHIP), or a job-based health plan. I also understand that if I become eligible for other qualifying health coverage, I must contact the Marketplace to end my Marketplace coverage and premium tax credit. If I don't, the person who files taxes in my household may need to pay back my premium tax credit.

- I understand that because the premium tax credit will be paid on my behalf to reduce the cost of health coverage for myself and/or my dependents:
    - I must file a federal income tax return for the tax year I enrolled in coverage.
    - If I'm married at the end of the tax year I enrolled in coverage, I must file a joint income tax return with my spouse.
- I also expect that:
    - No one else will be able to claim me as a dependent on their federal income tax return for the tax year I enrolled in coverage.
    - I'll claim a personal exemption deduction on my federal income tax return for the tax year enrolled in coverage for any individual listed on this application as my dependent who is enrolled in coverage through this Marketplace, and whose premium for coverage is paid in whole or in part by advance payments of the premium tax credit.
- If any information on my application changes:
    - I understand that it may impact my ability to get the premium tax credit.
    - I also understand that when I file my federal income tax return for the tax year I enrolled in coverage, the Internal Revenue Service (IRS) will compare the income on my tax return with the income on my application. I understand that if the income on my tax return is lower than the amount of income on my application, I may be eligible to get an additional premium tax credit amount. On the other hand, if the income on my tax return is higher than the amount of income on my application, I may owe additional federal income tax.