AUTHORIZATION FOR ENROLLMENT ASSISTANCE

Your CCA Certified & Delegated Agent: ☐ Andrew Vanos CA Lic#: 0G21740
☐ Thomas Feeney CA Lic#: 0G18420

Authorized Representative Name: _____

Authorized Representative Address: 2790 Harbor Blvd., Ste. 101, Costa Mesa, CA 92626 &
2127 Harbor Blvd., Costa Mesa, CA 92627 &
18582 Beach Blvd., Ste. C-1, Huntington Beach, CA 92648

Authorized Representative Phone Number: (800) 969-1428 Representative Email: info@CCAPlan.com

I,_____(Applicant) give my permission to the above named Authorized Representative (herein called "Representative") to give me information about my health coverage choices. This is to help me apply for and enroll in health coverage through a Covered California Health Insurance Plan or Medi-Cal.

I give permission for the Representative to see or use some of my Personally Identifiable Information and to help me enroll in health coverage. My Personally Identifiable Information may include my name, home address, email address, phone number, date of birth, social security number, financial information, and employment information.
In this form, the words "me" or "my" include my Authorized Representative.

I understand that:

1. The Representative will tell me about coverage choices I may qualify for, including Covered California Health Plans, Medi-Cal and the Medi-Cal Access Program.
2. The Representative cannot choose or recommend a health plan for me.
3. The Representative will make sure my Personally Identifiable Information is private and secure as required by law.
4. The Representative may create, collect, give out, access, keep, store, and/or use my Personally Identifiable Information and/or my Authorized Representative's Personally Identifiable Information only to perform the Certified Enrollment Representative duties. This may include giving my Personally Identifiable Information to Covered California, Covered California Health Plans, my certified agent, and the California Department of Health Care Services, which runs Medi-Cal. The Representative may not use my Personally Identifiable Information for any other purposes.
5. Representative duties also include:
   - Providing information and services in a fair, correct, and impartial way.
   - Providing information verbally and/or in writing about coverage options for which I may qualify in my language and in a way I can understand.
   - Providing information and help in a way that persons with disabilities can access and use.
   - Helping me choose a Covered California Health Plan or Medi-Cal or the Medi-Cal Access Program. If I consent, helping me apply for, enroll into, or renew coverage.
   - Referring me to agencies for help with a grievance, complaint, or question about my health plan, coverage, or a decision made by or about my plan or coverage.
6. The Representative may also offer public education activities. The Representative will not use my Personally Identifiable Information for this purpose.
7. If the information I give is wrong or incomplete, the Representative may not be able to help me make the best decisions. The Representative's help is based only on information I give.

Applicant Initials:_____

8. If the Representative can't help me, he or she will refer me to another Representative, or to the Covered California Service Center, who can help me.
9. The Representative will not charge me a fee. The help is free.
10. I must sign this form for the Representative to give help. If I do not sign this form, I can still apply for and enroll in health coverage through Covered California or Medi-Cal or the Medi-Cal Access Program, but the Representative will not be able to help me.
11. This authorization will expire when I communicate to the Representative that I wish to cancel my authorization. I may cancel or limit my authorization in writing at any time. I will notify the Representative if I choose to cancel my authorization.
12. The enrollment center needs your name and signature on this form to identify you. If you do not give your name and signature on this form, a Representative will not be able to help you.
14. I have Delegated Andrew Vanos as my certified agent with Covered CA and have given him access to my information through the covered CA portal.
13. I have identified the Representative named above as my Representative in my Covered CA portal.
14. I understand the Representative is not an employee of Covered CA. The representative is an employee of Siga Siga Enterprises, LLC. I further authorize the Agent of record to remove the representative from my account upon termination of the Representative's employment with Siga Siga Enterprises, LLC.
15. I acknowledge that the Representative who is helping me may or may not be licensed with the CA Department of Insurance or may or may not be Certified Enrollment Councilor or Agent with Covered CA.

Applicant, Sign and date on the lines:

Applicant Signature: _____ Date: _____

Applicant Print Name: _____

Case No.: _____

For Enrollment Representative:

I affirm under penalty of perjury that:

• I have been requested by the above named applicant to assist them with enrolling for Health Insurance through Covered CA

• I gave all information in this authorization form to the applicant in a language and way he or she understands.

• I ensured all information on this form was accessible to those with disabilities by providing disability-related modifications or accommodations when necessary, including auxiliary aids, Braille, large print or other tools and services.

• I explained to the consumer what information is Personally Identifiable Information and that this will only be used to determine eligibility for health coverage.

• I obtained oral authorization from the consumer consenting to the release of his or her Personally Identifiable Information to me in order to fulfill my duties as described in California Code of Regulations Title 10, Chapter 12, Article 8, section 6664.

Representative Signature: _____ Date: _____

Representative Printed Name: _____