

**CONSENT TO SERVE AS AN AUTHORIZED REPRESENTATIVE  
IN ORDER TO FACILITATE ENROLLMENT FOR APPLICANT**

**IMPORTANT INFORMATION FOR ANY PERSON APPOINTING AN AUTHORIZED  
REPRESENTATIVE\* AND FOR ANY INDIVIDUAL PERSON OR ORGANIZATION THAT IS  
AGREEING TO SERVE AS AN AUTHORIZED REPRESENTATIVE**

- One of the stated duties of the Silver State Health Insurance Exchange (Exchange) is to "Facilitate the Purchase and Sale of Qualified Health Plans." *NRS 695I.210.*
- An applicant can appoint an Authorized Representative to act on his or her behalf in applying for eligibility determination or redetermination.
- The Authorized Representative may act on behalf of the applicant in all matters with the Exchange. *CFR Sec 155.227 (a)*

**AUTHORIZED REPRESENTATIVE CONSENTS TO:**

- Maintain, or be legally bound to maintain, the confidentiality of any information regarding the applicant provided by the Exchange. *CFR Sec 155.227 (3)*
- Be responsible for fulfilling all responsibilities encompassed within the scope of the authorized representation to the same extent as the applicant he or she represents. *CFR Sec 155.227 (4)*
- Abide by *Codified Federal Regulations* and *Nevada Revised Statutes* pertaining to the Exchange.

I hereby appoint and give permission to the Authorized Representative identified below to assist my application and enrollment in a Qualified Health Plan and or Stand-Alone Dental Plan (SADP) offered through Nevada Health Link. By completing and signing this form, I agree to allow my Authorized Representative to collect required information and pursue enrollment on my behalf, in accordance with the Nevada Health Link Privacy Policy and applicable state and federal laws.

Applicant Name: _____	Date of Birth _____
Spouse Name: _____	Date of Birth _____
Address _____	Phone Number _____
Email _____	
Case/Application ID#: _____	
List Other Dependents: _____	
_____	

\*Authorized Representative is any person, (i.e. Navigator, CAC, Relative, EEF, or person licensed by DOI, etc.) appointed by the Applicant to serve as an Authorized Representative to facilitate enrollment for Applicant. \*\* Nevada Health Link Privacy Notice can be found at <https://www.nevadahealthlink.com/about-nevada-health-link/privacy-policy/> or you can request to review a copy before signing this document. To report fraud or abuse or file a complaint visit: [http://ag.nv.gov/Complaints/File\\_Complaint](http://ag.nv.gov/Complaints/File_Complaint) or call the Attorney General’s office at 775-684-1194 (N. Nevada) or (702) 486-3187.

I hereby appoint \_\_\_\_\_  
to serve as an Authorized Representative to facilitate my application on behalf of myself and anyone listed on this application.

\* I understand that my Authorized Representative may discuss my application with Nevada Health Link, see and disclose necessary information to Nevada Health Link, and act on my behalf on matters related to my application, including getting information about my application and signing my application on my behalf.

\* I understand that this information will be used for eligibility determination for enrollment in Qualified Health Plans (QHPs), Stand Alone Dental Plans (SADPs), Advanced Premium Tax Credits (APTC), and public health programs.

\* I understand that individuals on this form have the right to review the Nevada Health Link Privacy Notice before signing the form and to request a copy at any time.

\* I consent to the use of my Social Security Number by my Authorized Representative for the purpose of identification.

\* I attest that the information provided on this form is accurate and complete, to the best of my knowledge and/or belief. I understand and agree that any omissions or incorrect statements knowingly made on this form may invalidate the designation of my Authorized Representative.

\* I understand that I may revoke this authorization by notifying my Authorized Representative with Nevada Health Link in writing. If I revoke the authorization, it will not affect any actions already taken by my Authorized Representative.

\* I understand that I may request a copy of this completed authorization form.

\* For purposes of facilitating enrollment, unless revoked, this authorization permits my Authorized Representative to facilitate eligibility determination and enrollment on behalf of myself and anyone listed on this application for a period of twelve months from the date of signature.

Applicant or Enrollee Signature _____	Date _____
Spouse's Signature _____	Date _____
Authorized Representative's Signature _____	Date _____
Printed name of Authorized Representative, address, telephone number and, if applicable, Exchange ID No. or Nevada Division of Insurance Certification No.	
_____	
Plan Name _____	Metal Type _____
QHP	SADP      Medicaid/CHIP      Effectuated

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