PAYLUX ADVISORY GROUP INC.

HEALTH INSURANCE MARKETPLACE AUTHORIZATION

CLIENT INFORMATION

Client full legal name:	_____
Date of birth (optional for this authorization):	_____
Coverage year:	_____
Client email / phone:	_____

AUTHORIZATION

I authorize Paylux Advisory Group Inc. and the licensed insurance agent identified below to assist me with my request to enroll in or renew health coverage through the Health Insurance Marketplace for the coverage year written above. For that purpose, I authorize the agent to communicate with the Marketplace and, when applicable, an insurance carrier about my application, enrollment, renewal, and policy servicing, to the extent permitted by law and Marketplace requirements.

This authorization is limited to the purposes described above. It does not authorize anyone to create or change information on my application without my knowledge and consent, make a plan selection on my behalf without my authorization, or sign my name. I may ask for information about the scope of this authorization or withdraw it by contacting Paylux Advisory Group Inc., subject to any actions already taken in reliance on it.

AGENT / AGENCY DETAILS

Licensed agent name:	_____
Agent NPN (if applicable):	_____
Agency:	Paylux Advisory Group Inc.
Agency email:	info@payluxadvisorygroup.com
Agency phone:	1-800-888-7777

CLIENT ACKNOWLEDGMENT AND SIGNATURE

I have read and understand this authorization. I confirm that the information I provide is accurate to the best of my knowledge and that I am authorizing the assistance described above.

Client signature:	_____
Printed name:	_____
Date signed:	_____

DRAFT TEMPLATE — Have the agency's compliance or legal reviewer approve this authorization and confirm agent, Marketplace, recordkeeping, and privacy requirements before using it with clients.