

Client Information

PLEASE LIST ALL HOUSEHOLD MEMBERS REGARDLESS OF COVERAGE NEEDS

Individual

Spouse

Name				
Address				
City/ Zip code				
Phone #				
Email				
Date of Birth				
SS#				
Sex:	☐ Female	☐ Male	☐ Female	☐ Male
Tobacco:	☐ Yes	☐ No	☐ Yes	☐ No
Need Coverage:	☐ Yes	☐ No	☐ Yes	☐ No
Preferred Method of Communication	☐ Text	☐ Email	☐ Call	☐ Text ☐ Email ☐ Call

Dependents

Sex (F or M)	Name	DOB	SS#	Claimed on Taxes	Needs Coverage	Covered by Medicaid

Household Information	Answer
Are there any household dependents attending college full time? (If yes, please list first name & location)	☐ YES, _____ ☐ NO
Are any household dependents earning income over \$5,000 per calendar year? (If yes, please list first name, employer, and yearly earnings)	☐ YES, _____ ☐ NO
Are any household members ineligible or terminated from Medicaid in the last six months? (If yes, list names & dates)	☐ YES, _____ ☐ NO
Are any household members Native American and/or a member of a federally recognized tribe? (If yes, list the member's name and name of tribe)	☐ YES, _____ ☐ NO
Are all household members US citizens? (If no, list names and current status)	☐ YES ☐ NO, _____
Are any household members born outside of the United States? (If yes, list names and date of naturalization)	☐ YES, _____ ☐ NO

Continued on the back!

Income Section

NOT OPTIONAL & MUST BE COMPLETED

Please provide your best estimate of gross household income (before taxes and deductions) for the 2026 tax year. Attach supporting documents such as tax returns, W-2s, 1099s, or pay stubs if available. If not, complete the section below. Include all household members and all income sources.

Notes:

- Use gross income (before taxes)
- If income varies, estimate as best as possible
- Include all taxable income sources
- This information helps determine cost and plan options

Section 1: Household Income with Employment or Self-Employment

	Member 1	Member 2
Employer		
Employer Phone		
Amount		
Frequency		

Section 2: Other Household Income

	Individual	Spouse	Other
Social Security			
Retirement			
Unemployment			
Alimony			
Other Taxable Income			

Attestation (Must Sign & Date Below)

By signing below, I attest that all information provided within this form is accurate and complete to the best of my knowledge. I further attest that if I later discover that I omitted or incorrectly provide information on this document for the 2026 plan year that it can effect the cost of my coverage, overall out of pocket, or influence plan choices and recommendations in a negative manner. I understand that certain corrections and updates can be made to my tax credits and insurance plan throughout the year. I further agree and acknowledge, that I may not be able to select a different insurance plan altogether after open enrollment ends without a qualifying event and will hold harmless, The Benefit Partners Inc., DBA Senior Insurance & Retirement Advisors and its agents, administrative staff that assisted in the enrollment process.

Signature: _____ **Date:** _____

Centers for Medicare & Medicaid Services

I, [redacted] [primary household contact/insured], give my permission to **Mardee Downing Bice, Principal Agent & Administrative staff for Senior Insurance and Retirement Advisors** to serve as the licensed and certified 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 Federally Facilitated 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 purpose of one or more of the following:

- * Searching for an existing Marketplace application;
- * 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 pay for Marketplace premiums;
- * Providing ongoing account maintenance and enrollment assistance, as necessary; or Responding to inquiries from the Marketplace regarding my Marketplace application.

Read & Initial each statement below:

 I understand that the Agent will not use or share my personally identifiable information (PII) for any purposes other than those listed above. The Agent will ensure that my PII is kept private and safe when collecting, storing, and using my PII for the stated purposes above.

☐ 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 the above-mentioned Agent/Agency can only provide assistance based on the information I or my personal representative provide. If said information provided is inaccurate or incomplete, the Agent/Agency is not responsible for any negative outcome as a result throughout enrollment and the entire coverage year. (Examples: loss or reduction of tax credit, loss of insurance coverage, or tax credit repayment on a future tax return)

 I understand that I do not have to share additional personal information about myself or my health with the Agent/Agency staff beyond what is required to complete the application for eligibility and enrollment process. As a result, I further understand that if I choose to not share additional information with the Agent/Agency staff, it may possibly impair or impede the effectiveness of the Agent's counsel or plan recommendation of the best-suited health coverage for the upcoming plan year.

 I understand that the above-mentioned Agent/Agency will not charge me or my authorized representative a fee for any assistance provided.

 I understand that the Agent/Agency reserves the right to discontinue assisting me or my representative at any time during the enrollment period or upcoming coverage year if I fail to meet my responsibilities of one or more of the following items:

Failure to notify the Agent/Agency office that I am unable to make scheduled appointments and don't show up with no call/contact with the office;

Repeatedly failing to return messages and/or requests for missing information that have been requested by the Agent/Agency staff during the enrollment process or plan year;

Updating personal information as it changes during the enrollment process or anytime within the plan year;

Failure to pay insurance premium resulting in termination of insurance plan & Federal tax credits;

Failure to furnish required documents requested by the Federal Marketplace at enrollment or during the plan year, on or before the designated deadlines given by the Federal Marketplace;

Failure to provide respectful communication to Agent/Agency staff with all communication types during the enrollment process or throughout the plan year (examples: anger, aggression, profanity or derogatory language or remarks).

The Agent/Agency will be responsible for notifying me or my authorized representative in writing by email, fax, or mail if and when assistance with my health coverage and/or Federal Marketplace tax credits will no longer be provided to me from this office.

☐ I understand that my consent remains in effect until I revoke it, and I may revoke or modify my consent at any time by providing a written request to be delivered in person, mailed, faxed, or emailed to: Mardee Downing Bice/SIRA @ 1713 1st Avenue, Scottsbluff, info@seniorira.com or faxed to: 1-888-455-5590.

Primary Writing Agent:	Mardee Downing Bice
Agent National Producer Number:	8759470
Phone Number:	308-436-9314
Email Address:	info@seniorira.com
Name of Agency:	Senior Insurance & Retirement Advisors
Agency National Producer Number:	17589823
Owner of Agency:	The Benefit Partners Inc. (Mardee Downing Bice, Principal)
Phone Number:	308-436-9314
Email Address:	info@seniorira.com

Primary Contact: _____ Authorized Representative: _____

Phone Number: _____ Email Address: _____

Signature: _____ Date: _____