2025 Marketplace Application

Enroller: _____ Info gathered on _____ at _____ am/pm. Are you a current client of ours? ☐YES ☐NO If no, how did you hear about us? _____

CLIENT INFORMATION

Client Name: _____ Employer: _____ Employer Phone #: _____

Home Address: _____ City: _____ State: _____ Zip: _____ County: _____

Same Mailing Address: ☐YES ☐NO Address: _____ City: _____ State: _____ Zip: _____

Cell Phone #: _____ Can we text your cell phone: ☐YES ☐NO Home Phone #: _____ Marital Status: _____

Email Address: _____ Can we contact you via email: ☐YES ☐NO

Employer offer health insurance? ☐YES ☐NO If yes, how much are you charged for EMPLOYEE ONLY health insurance: _____

Spouse's Employer Name/#: _____ Modified Adjusted Gross Income for 2025: _____

Spouse's Employer Offer Insurance? ☐YES ☐NO If yes, how much is your spouse charged for EMPLOYEE ONLY health insurance: _____

LIST THE FOLLOWING INFORMATION ON EVERY PERSON CLAIMED ON YOUR TAX RETURN (whether they need insurance or not):

Name	Social Security Number	Date of Birth	Age	Sex	Use Tobacco	Does this person need insurance?	Receive Social Security Benefits?	Receive Medicare or Medicaid?	US Citizen or Permanent Resident?	2025 Expected Annual Income
Self										

Contact Acentria, formerly American Carolina Insurance, to assist you: Call (864) 269-9700. You can fax your application to (864) 269-7134 or email it to SCHealth@Acentria.com

PRIVACY/HIPPA Authorization: By signing or noted verbal code I hereby attest that I give authorization to the staff of American Carolina Insurance to act on my behalf to quote, enroll and/or service any insurance policy with HealthCare.gov or any insurance carrier with which I have chosen to enroll. ACI certifies that the information collected will be used for quoting, enrolling and/or servicing said policy. I confirm I have provided true answers to all questions on this form. I know that I may be subject to penalties under federal law if I intentionally provide false or untrue information. I know that I must notify ACI and/or the Marketplace if anything changes (and is different than) what I provided on this application. I understand that a change in my information could affect my eligibility. I confirm that next year I plan to file a federal income tax return. I also confirm that I am not offered affordable health coverage from my employer.

_____ _____

Signed Date