2026

2026

pennie Certified Broker

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APPLICANT INFORMATION

Existing Client: **Yes** **No**

Who is Your Agent / Who do you have an appointment with? Agent Name: ■ **A**lex Katsef ☐ Other_____

1

Name:	Date of Birth:	S/S#	Gender: **M** **F**	Coverage through a job, Medicare or Medicaid ■ **No**

Address:	Apt / Unit:	City:	State: *PA*	Zip:

Mobile Phone:	E-mail Address:	DL#	Citizen ☐ I-551 ☐ I-766 ☐ I-797 ☐ I-94 ☐	Smoker: ■ **No**

EMPLOYMENT INFORMATION

Current Employer:	Employer Address:	
Phone:	Fax:	E-mail:
Occupation:	------	Annual Income: ------

SPOUSE INFORMATION

2

Name:	Date of Birth:	S/S#	Gender: **M** **F**	Coverage through a job, Medicare or Medicaid **Yes** **No**

Mobile Phone:	E-mail Address:	DL#	Citizen ☐ I-551 ☐ I-766 ☐ I-797 ☐ I-94 ☐	Smoker: **Yes** **No**

TOTAL HOUSEHOLD INCOME

$$

$ _____

SPOUSE EMPLOYMENT INFORMATION

Current Employer:	Employer Address:	
Phone:	Fax:	E-mail:
Occupation:	------	Annual Income: ------

DEPENDANT'S INFORMATION

3	Dependent 1:	DOB	S/S#	**M** **F**	Coverage through a job, Medicaid, or CHIP **Yes** **No**	Citizen ☐ I-551 ☐ I-766 ☐ I-797 ☐ I-94 ☐
4	Dependent 2:	DOB	S/S#	**M** **F**	Coverage through a job, Medicaid, or CHIP **Yes** **No**	Citizen ☐ I-551 ☐ I-766 ☐ I-797 ☐ I-94 ☐
5	Dependent 3:	DOB	S/S#	**M** **F**	Coverage through a job, Medicaid, or CHIP **Yes** **No**	Citizen ☐ I-551 ☐ I-766 ☐ I-797 ☐ I-94 ☐
6	Dependent 4:	DOB	S/S#	**M** **F**	Coverage through a job, Medicaid, or CHIP **Yes** **No**	Citizen ☐ I-551 ☐ I-766 ☐ I-797 ☐ I-94 ☐
7	Dependent 4:	DOB	S/S#	**M** **F**	Coverage through a job, Medicaid, or CHIP **Yes** **No**	Citizen ☐ I-551 ☐ I-766 ☐ I-797 ☐ I-94 ☐
8	Dependent 4:	DOB	S/S#	**M** **F**	Coverage through a job, Medicaid, or CHIP **Yes** **No**	Citizen ☐ I-551 ☐ I-766 ☐ I-797 ☐ I-94 ☐
9	Dependent 4:	DOB	S/S#	**M** **F**	Coverage through a job, Medicaid, or CHIP **Yes** **No**	Citizen ☐ I-551 ☐ I-766 ☐ I-797 ☐ I-94 ☐

AKNOWLEGEMENT

I certify that I have received a copy of the Privacy Policy and that I have entered all information in the Health Insurance Marketplace truthfully and accurately. I attest that I have created a dedicated email address to use for all correspondence to and from the Health Insurance Marketplace and/or AJ Insurance Partners or its affiliates. The information supplied on this application and any signed addendum is accurate and complete to the best of my knowledge. No material information has been written or omitted on any person applying. I understand that if my signature and date do not appear and/or my answers are incomplete, that application will be either rejected or returned for completion.

Applicant Signature: ✓	Date:	Who is on Policy: 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐

MEMBER ID:	**FOR OFFICE USE ONLY**	PCP	
Plan Name: ------	***Payment: $***	***Full Premium: $***	***Starting Date:***

DESIGNED BY JOSEPH KHAMIS, VERSION 011, SEPTEMBER 2024

Please bring the following documents to your appointment: 1. Income documents such as a resent pay stub, your most resent 1099/W2 Forms or Tax Returns. 2. Proof of citizenship or immigration such as US Passport, Certificate of Citizenship, Certificate of Naturalization, Green Card or Work Authorization card.

Privacy Act Statement

The Patient Protection and Affordable Care Act (Public Law No. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law No. 111-152), and the Social Security Act authorizes Pennie to collect the information on your application and any necessary supporting documentation, including social security numbers, to determine whether you and the listed people on your application are eligible for health coverage or help paying for health coverage.

Pennie needs the information you provided us on your application about yourself and the other people included in your household to determine eligibility for: (1) enrollment in a qualified health plan through Pennie, (2) insurance affordability programs (such as Medicaid, APTC, and CSR), and (3) certifications of exemption from the individual responsibility requirement. As part of that process, Pennie will electronically verify the information you provided on your application; communicate with you or your authorized representative, if you choose to have one; and eventually provide the information to the health plan you select so that they can enroll any eligible individuals in a qualified health plan or insurance affordability program. Pennie will also use the information in the future to conduct activities such as verifying your continued eligibility for health coverage or help paying for health coverage, processing appeals, reporting on and managing the insurance affordability programs for eligible individuals, performing oversight and quality control activities, combatting fraud, and responding to any concerns about the security or confidentiality of the information.

While providing the information we ask you on the application (including social security numbers and documentation of your immigration status) is voluntary, failing to provide the information may delay or prevent you from obtaining health coverage or help paying for health coverage through Pennie. If you don't provide correct information on this form or knowingly and willfully provide false or fraudulent information, you may be subject to a penalty and other law enforcement action.
In order determine if you and the people on your application are eligible for health coverage, or help paying for health coverage, and to operate Pennie, we will electronically check the information you provided us on your application with the information in other electronic data sources. Such data sources include:

1. We will need to share your information with other federal and state government agencies, such as the Internal Revenue Service (IRS), the Social Security Administration (SSA), and the United States Department of Homeland Security (DHS), the United States Department of Health and Human Services, and the Pennsylvania Department of Human Services;

2. Other electronic data sources, including customer reporting agencies;

3. Employers identified on applications for eligibility determinations;

4. Applicants/enrollees;

5. The authorized representatives of applicants/enrollees;

6. Agents, Brokers, and issuers of Qualified Health Plans, as applicable, who are certified by Pennie to assist applicants/enrollees and who have been authorized to help applicant/enrollees;

7. Contractors we engage to help run Pennie; and

8. Anyone else as required by law.

This statement provides the notice required by the Privacy Act of 1974 (5 U.S.C. § 552a(e)(4)).

Record of the customer's consent:

Print name _____ Signature ✓_____ Date:_____