Other formats and languages
You can get this document in other languages, large print, braille or a format you prefer free of charge. Contact Explore Health at explorehealth@oha.oregon.gov or 855-268-3767 (voice). We accept all relay calls.

Explore Health Unified Authorization to Assist

Section 1: Type of Enrollment Partner Authorized

☐ **Insurance Agent**
A licensed insurance agent is authorized to recommend plans, provide guidance, and assist consumers with applying for, enrolling in, and maintaining coverage through Explore Health.

☐ **Assister/Community Partner**
A certified assister or community partner organization is authorized to provide unbiased application and enrollment assistance for Oregon Health Plan (OHP) programs, qualified health plans (QHPs), and related affordability programs. Assisters may not recommend plans.

Section 2: Insurance Agent Information (if applicable)

Name of insurance agency: _____

Agency owner: _____

Owner phone: _____

Owner email address: _____

Name of primary writing agent: _____

Agent National Producer Number (NPN): _____

Agent phone: _____

Agent email address: _____

Section 3: Assister/Community Partner Information (if applicable)

Name of community partner organization: _____

Name of application assister: _____

Oregon Health Authority (OHA) assister ID: _____

Assister email address: _____

Assister phone: _____

Section 4: Applicant Information

Primary applicant and name (*first, middle, last*): _____

Primary applicant date of birth: _____

Primary applicant phone: _____

Primary applicant email address: _____

Names and birthdates of other adults on application: _____

Number of household members 19 and over: _____

Section 5: Scope of Authorization

I give my permission to the Enrollment Partner listed above to serve as the Enrollment Partner for myself and my entire household, if applicable, for purposes of applying for and enrollment in coverage offered through Explore Health, Oregon's health insurance marketplace. By consenting to this agreement, I authorize the above-mentioned Enrollment Partner to view and use the confidential information provided by me in writing, electronically, in person, or by telephone for the purposes of only one or more of the following:

- Searching for an existing Explore Health application;
- Completing an application for eligibility and enrollment in an Explore Health qualified health or dental plan or other government insurance affordability programs, such as Oregon Health Plan (Medicaid/Children's Health Insurance Program (CHIP)/Basic Health Program), premium tax credits, or cost-sharing reductions to help pay for health insurance costs;
- Providing ongoing account maintenance and enrollment assistance, as necessary; or
- Responding to inquiries from Explore Health regarding my Explore Health application or enrollment.

OHP Assistance (Assisters only)

I authorize Oregon Health Authority (OHA), Oregon Department of Human Services (ODHS), and Explore Health to share the following information with my community partner organization and assister:

- My application
- Enrollment details
- Enrollment status
- Plan benefits
- Protected health information (PHI)

I understand that my Enrollment partner may not ask about my immigration status or the members of my household or share any information about my application unless authorized by me.

I understand assisters/community partners may not recommend a coordinated care organization (CCO) or any health insurance plan.

I understand these organizations must protect my information and may not share information about mental health, HIV/AIDS, drug or alcohol treatment, or genetic tests without additional authorization.

Section 6: Privacy and Security

I understand the Enrollment Partner must:

- Use my personally identifiable information (PII) or personal health information (PHI) **only** for authorized assistance purposes;
- Protect my information from unauthorized access, use, or disclosure;
- Collect, use, and disclose only the minimum necessary information;
- Maintain secure storage and transmission of my information;
- Follow all privacy rules required by Explore Health, OHA, and ODHS.

I understand I do not have to share additional personal information with my Enrollment Partner beyond what is required for completing my application.

Section 7: Applicant Responsibilities

I understand that:

- I must provide true and correct information on my application.
- I must respond to notices of missing or incorrect information when asked.
- I may receive help or referrals to assistance in a language I speak or prefer.

Section 8: Revoking or Ending Consent

Canceling authorization does not apply to information already shared. My authorization remains valid until I notify OHA/ODHS and Explore Health that I no longer wish to work with this Enrollment Partner or until I request assistance from another Enrollment Partner.

If my Enrollment Partner is an Insurance Agent:

I may revoke or modify my consent at any time by contacting the agent, agency, or agency owner listed above. I may also log in to my Applicant Dashboard and revoke consent or contact Explore Health by calling 855-268-3767 (relay calls welcome) Monday to Friday 8 a.m. to 5 p.m. PST.

If my Enrollment Partner is an Assister/Community Partner:

I may revoke my authorization by logging in to my Applicant Dashboard or contacting Explore Health by calling 855-268-3767 (relay calls welcome) Monday to Friday 8 a.m. to 5 p.m. PST. I must also notify OHA/ODHS if I wish to revoke consent from my assister/community partner by calling 800-699-9075 (relay calls welcome) or by emailing Oregon.Benefits@odhsoha.oregon.gov.

Section 9: Signature

Signature of Primary Applicant: _____

Date Signed (mm/dd/yyyy): _____

Explore Health: Oregon's Health Insurance Marketplace
PO Box 191
Salem, OR 97308
855-268-3767 (Relay calls welcome)
ExploreHealthOR.gov