

# Authorized Representative Form

An Authorized Representative is a trusted person who would be given permission to talk about an application or appeal request with us, see your information, and act for you on matters related to the application or appeal, including getting information about your application or appeal request and signing your application or appeal request on your behalf. This person takes legal responsibility for the information provided on your application or appeal request. If you do not want an authorized representative, you do not need to fill out this form.

What would you like to do?

- Add an authorized representative, complete Section 1**
- Change your current Authorized Representative, complete Section 2**
- Revoke permission for your current Authorized Representative, complete Section 3**

## Section 1 Add an Authorized Representative

1. Name of authorized representative (First name, Middle name, Last name, & Suffix)		
2. Address		3. Apartment or suite number
4. City	5. State	6. ZIP code
7. Phone number <div style="text-align: right;">Ext. _____</div>		Phone Type: <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work
8. Email address		
9. Company/Organization name (if applicable)		10. Company/Organization ID number (if applicable)

By signing, you allow this person to sign your application or appeal request, get official information about this application or appeal request, and act for you on all future matters with this agency.

11. Your signature	12. Date (mm/dd/yyyy)
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I, the **authorized representative**, would like to submit proof of a legal reason that **THE APPLICANT** cannot represent themselves. (Please provide one of the following documents with this application or appeal request when it is submitted: a power of attorney, court order establishing legal guardianship, a copy of a photo ID of the applicant who you are representing as his/her authorized representative, or other legal document explicitly stating that you may legally act on behalf of the customer.)

## Section 2 Change your Authorized Representative

1. Name of new authorized representative (First name, Middle name, Last name, & Suffix)		
2. Address		3. Apartment or suite number
4. City	5. State	6. ZIP code
7. Phone number Ext. _____		Phone Type: <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work
8. Email address		
9. Company/Organization name (if applicable)		10. Company/Organization ID number (if applicable)

By signing, you allow this person to sign your application or appeal request, get official information about this application or appeal, and act for you on all future matters with this agency.

11. Your signature	12. Date (mm/dd/yyyy)
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I, the **authorized representative**, would like to submit proof of a legal reason that **THE APPLICANT** cannot represent themselves. (Please provide one of the following documents with this application or appeal request when it is submitted: a power of attorney, court order establishing legal guardianship, a copy of a photo ID of the applicant who you are representing as his/her authorized representative, or other legal document explicitly stating that you may legally act on behalf of the customer.)

## Section 3 Revoke Permission for Authorized Representative

This Authorized Representative will no longer have permission to talk about your application or appeal request with us, see your information, or act for you on matters related to the application or appeal request, including getting information about your application or appeal and signing your application or appeal request on your behalf.

1. Name of authorized representative you wish to revoke (First name, Middle name, Last name, & Suffix)		
2. Phone number Ext. _____		Phone Type: <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work
3. Company/Organization name (if applicable)		4. Company/Organization ID number (if applicable)

By signing, you are no longer allowing this person to sign your application or appeal request, get official information about this application or appeal, and act for you on all future matters with this agency.

5. Your signature	6. Date (mm/dd/yyyy)
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## Section 4 Submit Completed Form by Mail, Fax, or by Uploading to Your Marketplace Account

Connect for Health Colorado  
Report Account Changes  
P.O. Box 35033  
Colorado Springs, CO 80935

Fax: 1-855-346-5175

ConnectforHealthCO.com

1-855-PLANS-4-YOU (1-855-752-6749)

**Note:** If you need help in a language other than English, call and tell the customer service representative the language you need.

**En Español:** Llame a nuestro centro de servicio gratis para ayuda en Español, al 1-855-PLANS-4-YOU (1-855-752-6749). TTY/TDD: 1-855-346-3432