FAX 502-848-4099

TO: DCBS Help Desk

FROM: Health Benefit Exchange Assister

Organization/Assister Group:_____

Assister Name/#: _____

Phone: _____

Email:_____

DATE:

SUBJECT: **Emergency Request for Assister Association**

REASON FOR EMERGENCY:

ANY ADDIITONAL CLIENT INFORMATION NOT INCLUDED ON CONSENT FORM:

PAGES: **INCLUDE**
Authorization Consent Form Appendix B for Application Assisters (AA) benefind & HealthCare.gov