Small Business Health Options Program (SHOP)

Application for Employees

COVERED CALIFORNIA™ | FOR SMALL BUSINESS

Complete this application to apply for SHOP health coverage from your employer.

THINGS TO KNOW

Go online

Visit **CoveredCA.com/ForSmallBusiness**. You'll be able to see details about Covered California's small business health insurance marketplace.

Get help

Ask your employer who to call with questions

- **Online: CoveredCA.com/ForSmallBusiness**
- **Phone:** Call our Service Center at (877) 453-9198
- **En Español:** Llame a nuestro centro de ayuda gratis al (877) 453-9198

What happens next?

You'll return your completed, signed application to your employer. Your employer will send us your completed, signed application.

Alternatives

If your share of the cost of employee-only coverage is more than 9.5% of your household income, you may able to get help paying for coverage through Covered California's individual marketplace. Visit **CoveredCA.com** to learn more.

Your information is private.

- We'll keep your information private as required by law.
- Your answers on this application will only be used to see if you qualify and to enroll you in health coverage from Covered California for Small Business.

NEED HELP WITH YOUR APPLICATION? Contact your employer or your employer's Covered California Certified Insurance Agent with questions, visit **CoveredCA.com/ForSmallBusiness** or call us at (877) 453-9198. Para obtener una copia de este formulario en Español, llame (877) 453-9198.

Who is your employer?

Employer name & address

Employer phone number
( ) –

Not interested in SHOP health coverage?

If you don't want SHOP health coverage from your employer, skip to Step 6 on page 4.

STEP 1 I'm interested in SHOP insurance from this employer.

Information about you, the employee.

1. First name, Middle name, Last name, & Suffix

2. Social Security Number or Tax ID Number	3. Date of birth (mm/dd/yyyy)		
4. Home address			5. Apartment or suite number
6. City	7. State	8. ZIP code	9. County
10. Mailing address (if different from home address)			11. Apartment or suite number
12 City	13. State	14. ZIP code	15. County

16. Email address (OPTIONAL)

17. Phone number ☐ Cell ☐ Home ☐ Work
( ) –

18. Other phone number ☐ Cell ☐ Home ☐ Work
( ) –

19. Cal-COBRA/COBRA Applicants: ☐ Cal-COBRA ☐ COBRA

Cal-COBRA/COBRA effective date: _____
(Cal-COBRA applicants must submit first month's premium)

20. For CalCOBRA/COBRA applicants, indicate qualifying event :

☐ Termination of employment ☐ Death of employee
☐ Reduction of hours ☐ Child no longer eligible
☐ Divorce/Legal separation ☐ Medicare entitlement

Date of Qualifying Event: _____

21. Marital Status: ☐ Single ☐ Married ☐ Domestic Partnership (DP)

22. Preferred spoken or written language (OPTIONAL—if not English)

23. What is the preferred method of communication? ☐ Mail ☐ Email ☐ Phone

Tell us about your race Please tell us about yourself. This information is confidential and will only be used to make sure that everyone has the same access to health care. It will not be used to decide what health insurance you qualify for.

24. Are you of Hispanic/Latino, or Spanish origin? (OPTIONAL) ☐ Yes ☐ No If yes, check which one(s): ☐ Other Hispanic, Latino or Spanish origin: _____
☐ Mexican, Mexican American, Chicano ☐ Salvadoran ☐ Puerto Rican ☐ Cuban ☐ Guatemalan

25. Race (OPTIONAL—Check all that apply.)

☐ White
☐ Black or African American
☐ American Indian or Alaska Native
☐ Asian Indian
☐ Cambodian
☐ Chinese
☐ Filipino
☐ Hmong
☐ Japanese
☐ Korean
☐ Laotian
☐ Vietnamese
☐ Native Hawaiian
☐ Guamanian or Chamorro
☐ Samoan
☐ Other _____

26. If you're American Indian or Alaska Native, tell us the state and the name of your federally-recognized tribe (optional):

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continued on next page ➡

STEP 2 Please tell us about yourself and your eligible enrolling dependents and indicate your SHOP Health Insurance plan selection.

California law defines a dependent for health care coverage in the following way:
"Dependent" means the spouse or registered domestic partner, or child, of an eligible employee, subject to applicable terms of the health care service plan contract covering the employee, and includes dependents of guaranteed association members if the association elects to include dependents under its health coverage at the same time it determines its membership composition.

EMPLOYEE	LAST NAME (FAMILY NAME)	FIRST NAME	M.I.	SSN / TAX ID #	GENDER (M/F)
	HOME ADDRESS	MAILING ADDRESS			
	BIRTHDATE MM / DD / YYYY	NAME OF HEALTH PLAN SELECTED	DENTAL PLAN SELECTED, IF APPLICABLE		
SPOUSE OR DOMESTIC PARTNER	LAST NAME (FAMILY NAME)	FIRST NAME	M.I.	SSN / TAX ID #	GENDER (M/F)
	HOME ADDRESS	MAILING ADDRESS			
	BIRTHDATE MM / DD / YYYY	ARE YOU A DOMESTIC PARTNER? Y / N	IF YES, IS YOUR PARTNERSHIP REGISTERED WITH THE STATE OF CALIFORNIA? Y / N	DENTAL PLAN SELECTED, IF APPLICABLE	
CHILD	LAST NAME (FAMILY NAME)	FIRST NAME	M.I.	SSN / TAX ID #	GENDER (M/F)
	HOME ADDRESS	MAILING ADDRESS			
	BIRTHDATE MM / DD / YYYY	IS CHILD **BOTH** DISABLED **AND** 26 YEARS OLD OR OLDER? Y / N	DENTAL PLAN SELECTED, IF APPLICABLE		
CHILD	LAST NAME (FAMILY NAME)	FIRST NAME	M.I.	SSN / TAX ID #	GENDER (M/F)
	HOME ADDRESS	MAILING ADDRESS			
	BIRTHDATE MM / DD / YYYY	IS CHILD **BOTH** DISABLED **AND** 26 YEARS OLD OR OLDER? Y / N	DENTAL PLAN SELECTED, IF APPLICABLE		
CHILD	LAST NAME (FAMILY NAME)	FIRST NAME	M.I.	SSN / TAX ID #	GENDER (M/F)
	HOME ADDRESS	MAILING ADDRESS			
	BIRTHDATE MM / DD / YYYY	IS CHILD **BOTH** DISABLED **AND** 26 YEARS OLD OR OLDER? Y / N	DENTAL PLAN SELECTED, IF APPLICABLE		

*Can be found in your selected plans provider directory.

☐ **My employer does not offer dependent coverage and I am interested in information on how I can obtain other coverage for my dependents. I wish to have someone contact me to help me understand my options.**

Employer ____

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continued on next page ➡

STEP 3 Covered California arbitration agreement

I understand that, if I select a Health Plan that uses mandatory binding arbitration to resolve disputes, I am agreeing to arbitrate claims that relate to my or a dependent's membership in the Health Plan (except for Small Claims Court cases and claims that cannot be subject to binding arbitration under governing law). I understand that any dispute between myself, my heirs, relatives, or other associated parties on the one hand and the Health Plan, any contracted health care providers, administrators, or other associated parties on the other hand for alleged violation of any duty arising out of or related to membership in the Health Plan, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is in the Health Plan's coverage document, which is available for my review.

Signature of Applicant (or financially-responsible party if Applicant is under the age of 18)	Date (mm/dd/yyyy)

Print Name

STEP 4 If a Certified Insurance Agent helped you complete this application, please obtain their signature below.

☐ **I did not use a Certified Insurance Agent.**

The applicant completed and executed this application, and I assisted the applicant by offering advice in providing responses to questions. I advised the applicant that he/she should answer all such questions completely and truthfully and that no information requested should be withheld. I explained to the applicant, in easy-to-understand language, the risk to the applicant of providing inaccurate information and the applicant understood the explanation. To the best of my knowledge, based on what the applicant disclosed to me, the information in this application is accurate and complete. **I understand that if any portion of this statement signed by me is false, I may be subject to civil penalties of up to $10,000 as authorized under California Health and Safety Code Section 1389.8 and Insurance Code Section 10119.3.**

Signature of Certified Insurance Agent

Print Name	Date

STEP 5 Read & sign this application.

- I am signing this application under penalty of perjury, which means I've provided true answers to all of the questions to the best of my knowledge. I know that I may be subject to penalties under federal law if I intentionally provide false or untrue information.
- I know that my information on this form will only be used to determine eligibility for health coverage and will be kept private as required by law. If I'm eligible, it will be used to help me enroll.
- I know that I must tell Covered California for Small Business if anything changes from what I wrote on this application. I can call my employer, my employer's Covered California Certified Insurance Agent or call **(877) 453-9198** to report changes.
- I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting www.hhs.gov/ocr/office/file.

Signature of Applicant	Date (mm/dd/yyyy)

Employer _____

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continued on next page ➡

STEP 6

Complete this section if you are declining coverage from your employer for you or your dependents.

I am declining coverage for (check all that apply):

- ☐ Self
- ☐ Spouse/Domestic Partner
- ☐ Child(ren)

Reason for declining coverage:

- ☐ Covered by spouse's/domestic partner's group plan
- ☐ Covered by individual policy
- ☐ Covered by Tricare
- ☐ Coverage is too expensive.
  (You may be eligible for a Federal subsidy through the Covered California Individual Marketplace.)
- ☐ Covered by Medicare
- ☐ Covered by Medi-Cal
- ☐ Covered by other: _____

List names of all dependents declining coverage:

_____ _____

_____ _____

_____ _____

Employee name

Signature of Employee | Date (mm/dd/yyyy)

Employer _____

STEP 7

Return your completed, signed application to your employer.

Your employer will send us your application, and we will contact you if we need additional information or to let you know you have been approved for coverage.

If you are not registered to vote where you live now and would like to apply to register to vote today please visit **registertovote.ca.gov** or call 1-800-345-VOTE (8683).

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