

# Small Business Health Options Program (SHOP)



FOR **SMALL BUSINESS**

## Application for Employers

Covered California for Small Business offers a new way for small employers to offer health insurance to employees.

THINGS TO KNOW



### Who can use this application?

#### To apply for SHOP your business must:

- Have a primary business address in California, or offer coverage to each eligible employee through the SHOP servicing that employee's primary worksite,
- Have 1 to 100 Full-Time Equivalent (FTE) employees\*, and
- Offer coverage through SHOP to all full-time employees, that average 30+ hours per week



### What you will need to apply

- A copy of your Local Business License
  - A copy of your reconciled DE-9C
  - Additional business documentation (see Step 1)
  - Eligible employee information
    - Full name
    - Social Security Number or Tax Identification Number
    - Date of birth
  - Home address
  - Phone number
  - COBRA/Cal-COBRA status
  - Dependent information (if offering dependent coverage)
- Employees who decline coverage must still complete an employee application and sign the appropriate section of the application.*



### Get help

- **Online:** [www.CoveredCA.com/ForSmallBusiness](http://www.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**
- Contact your Certified Insurance Agent
- Contact the Covered California for Small Business Service Center for information on how to find a Certified Insurance Agent (877) 453-9198



### What happens next?

You'll send this form and your employees' completed, signed applications to the address on page 6. You'll hear back from us within 1–2 weeks. We'll let you know if you're eligible to buy insurance for your small business.

#### Your information is private.

- We'll keep your information private as required by law.
- Your answers on this form will only be used to see if your business or organization is eligible for SHOP and, if eligible, to facilitate enrollment.

\* Please refer to page 3 for more information regarding Full-Time Equivalent (FTE) employees and how to arrive at this calculation.

# STEP 1

## To verify eligibility for SHOP:

You must provide the following:

- Copy of Local Business License
- DE-9C reconciled by the employer

AND, the additional documents below:

You are a:	And have been in business for:	You must provide the following:		
		Document 1 (Choose one)	Document 2 (Choose one)	Document 3 (Choose one)
<input type="checkbox"/> <b>Sole Proprietor</b>	<input type="checkbox"/> Less than 3 months	<input type="checkbox"/> Local Business License or <input type="checkbox"/> Fictitious Business Name Filing	<input type="checkbox"/> DE-9C or <input type="checkbox"/> Payroll Records for 30 Days	
	<input type="checkbox"/> 3 months or more	<input type="checkbox"/> Schedule C or <input type="checkbox"/> Local Business License or Fictitious Business License	<input type="checkbox"/> DE-9C and <input type="checkbox"/> Schedule C (if owner is enrolling)	
<input type="checkbox"/> <b>Corporation</b>	<input type="checkbox"/> Less than 3 months	<input type="checkbox"/> Articles of Incorporation (Filed and Stamped)	<input type="checkbox"/> DE-9C or <input type="checkbox"/> Payroll Records for 30 Days	<input type="checkbox"/> Statement of Information (if Officers are offered coverage and not listed on DE-9C) or <input type="checkbox"/> Corporate Meeting minutes listing all officers names
	<input type="checkbox"/> 3 months or more	<input type="checkbox"/> DE-9C	<input type="checkbox"/> Statement of Information (if Officers are offered coverage and not listed on DE-9C)	
<input type="checkbox"/> <b>Partnership</b>	<input type="checkbox"/> Less than 3 months	<input type="checkbox"/> Partnership Agreement	<input type="checkbox"/> Federal Tax ID Appointment letter	<input type="checkbox"/> DE-9C or <input type="checkbox"/> Payroll records for 30 days
	<input type="checkbox"/> 3 months or more	<input type="checkbox"/> DE-9C	<input type="checkbox"/> Current Schedule K-1 (if Partners are not listed on DE-9C) or <input type="checkbox"/> Partnership Agreement and Fed Tax ID Appointment letter (if Schedule K-1 not available yet)	
<input type="checkbox"/> <b>Limited Partnership (LP)</b>	<input type="checkbox"/> Less than 3 months	<input type="checkbox"/> Partnership Agreement	<input type="checkbox"/> Federal Tax ID Appointment letter	<input type="checkbox"/> DE-9C or <input type="checkbox"/> Payroll records for 30 days
	<input type="checkbox"/> 3 months or more	<input type="checkbox"/> DE-9C (Limited Partners of a LP are not eligible for coverage unless they appear on a DE-9C)	<input type="checkbox"/> Current Schedule K-1 (if General Partners are not listed on DE-9C) or <input type="checkbox"/> Partnership Agreement and Fed Tax ID Appointment letter (if Schedule K-1 not available yet)	
<input type="checkbox"/> <b>Limited Liability Partnership (LLP)</b>	<input type="checkbox"/> Less than 3 months	<input type="checkbox"/> Partnership Agreement or <input type="checkbox"/> Federal Tax ID Appointment letter	<input type="checkbox"/> DE-9C or <input type="checkbox"/> Payroll Records for 30 Days	
	<input type="checkbox"/> 3 months or more	<input type="checkbox"/> DE-9C	<input type="checkbox"/> Current Schedule K-1 (if Partners are not listed on DE-9C) or <input type="checkbox"/> Partnership Agreement and Fed Tax ID Appointment letter (if Schedule K-1 not available yet)	
<input type="checkbox"/> <b>Limited Liability Company (LLC)</b>	<input type="checkbox"/> Less than 3 months	<input type="checkbox"/> Articles of Organization with Operating Agreement or <input type="checkbox"/> Statement of information	<input type="checkbox"/> DE-9C or <input type="checkbox"/> Payroll Records for 30 Days	
	<input type="checkbox"/> 3 months or more	<input type="checkbox"/> DE-9C	<input type="checkbox"/> Current Schedule K-1 for partnership or a Schedule C for sole proprietorship (if managing members are not listed showing wages on DE-9C) or <input type="checkbox"/> Statement of Information or Articles of Organization with Operating Agreement (if no Schedule K-1 or Schedule C)	

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## STEP 2

## Tell us about your business.

Employers must be located within the same state they're buying health coverage and must offer coverage to all full-time employees (those working on average 30+ hours per week).

1. Business legal name		2. Federal Employer Identification Number (FEIN)	
3. Doing business as (DBA)		4. State Employer Identification Number (SEIN)	
5. Which name do you want to use for reporting purposes? <input type="checkbox"/> Business legal name <input type="checkbox"/> DBA			
6. Organization type <input type="checkbox"/> Private <input type="checkbox"/> Nonprofit <input type="checkbox"/> Government <input type="checkbox"/> Church/church affiliated			
7. Total number of Full-Time Equivalent (FTE) employees*?	8. Total number of eligible employees?	9. Requested Coverage Effective Date	10. SIC code
11. <input type="checkbox"/> Yes, I'm offering dependent health coverage.** <i>(See Step 7 to indicate optional employer contribution.)</i>	<input type="checkbox"/> No, I'm not offering dependent health coverage	12. <input type="checkbox"/> Yes, I'm offering coverage to non-registered domestic partners.	<input type="checkbox"/> No, I'm not offering coverage to non-registered domestic partners.
13. My company is subject to: <input type="checkbox"/> Federal COBRA <input type="checkbox"/> Cal-COBRA		14. Have you employed 20 or more employees for 20 or more weeks during the current or preceding calendar year? <input type="checkbox"/> Yes <input type="checkbox"/> No	

## STEP 3

## Tell us who to contact about this application.

**Primary Contact** (official communications will be addressed to the primary contact)

1. First name, Last name, & Suffix	
2. Phone number (    )    —	3. Email address (OPTIONAL)
4. What is the preferred method of communication? <input type="checkbox"/> Mail <input type="checkbox"/> Email <input type="checkbox"/> Phone	5. Preferred spoken or written language (OPTIONAL—if not English)

**Authorized Representative** (if you want to name someone as your authorized representative — OPTIONAL)

6. First name, Last name, & Suffix	
7. Phone number (    )    —	8. Email address (OPTIONAL)

### Company Addresses

9. California business address – street address 1 (must be a California street address)				
10. Street address 2				
11. City	12. State	13. ZIP code	14. County	
15. Is your mailing address the same as your California business address? <input type="checkbox"/> Yes <input type="checkbox"/> No		16. Is your billing address the same as your California business address? <input type="checkbox"/> Yes <input type="checkbox"/> No		
17. Mailing address	18. City	19. State	20. ZIP code	21. County
22. Billing address				
23. City	24. State	25. ZIP code	26. County	

### Agent Information (if applicable)

1. First name, Middle name, Last name, & Suffix	
2. General agency name (if applicable)	3. CA insurance license #
4. Covered California Certified Insurance Agent <input type="checkbox"/> Yes <input type="checkbox"/> No	

**?** **NEED HELP WITH YOUR APPLICATION?** Contact your Certified Insurance Agent with questions – visit [www.CoveredCA.com](http://www.CoveredCA.com), or call us at **(877) 453-9198**.

\* Please refer to page 3 for more information regarding Full-Time Equivalent (FTE) employees and how to arrive at this calculation.

\*\* If you employ at least 50 Full-Time Equivalent employees, you are required to offer coverage to all dependent children up to the age of 26 or face a monetary penalty. See Section 4980H of the Internal Revenue Code.

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## What is a full-time equivalent employee?

For the purposes of determining whether an employer is a small or large employer as defined by the Affordable Care Act (ACA) and applicable California law, the employer is required to calculate its total number of "Full-Time Equivalent" (FTE) employees. This number determines whether the employer is eligible to participate in Covered California for Small Business. The FTE number is also important for determining whether an employer is an Applicable Large Employer (ALE) and subject to the "Pay or Play" mandate under Section 4980H of the Internal Revenue Code.

An FTE employee is not an actual employee but a calculation involving all part-time and full-time employees who worked during the preceding calendar year or calendar quarter. In determining whether to use the calendar year or calendar quarter test, the calculation shall use the test that ensures eligibility if only one test would ensure eligibility. See Section 1357.500(k)(1) of the Health and Safety Code for further information. If the employer did not exist in the prior calendar year or calendar quarter, the employer shall determine the average number of employees who are reasonably expected to work on business days in the current calendar year. That figure will establish whether the employer is eligible for coverage through Covered California for Small Business.

For purposes of determining whether an employer is an Applicable Large Employer that is subject to the "Pay or Play mandate," the calculation only involves the employment figures from the prior calendar year. See Section 4980H of the Internal Revenue Code and the IRS website for more details.

### Instructions

1. Calculate your total FTE number. For information on how to perform the FTE calculation, please visit the IRS website at <https://www.irs.gov/uac/Small-Business-Health-Care-Tax-Credit-Questions-and-Answers-Determining-FTEs-and-Average-Annual-Wages>.
2. Use the final FTE figure as the number you use to fill in box 7 on page 2 of this application

### Important to Know:

- If your FTE number is at least 50, you are required to offer coverage to all dependent children up to the age of 26 or face a monetary penalty. See Section 4980H of the Internal Revenue Code.
- Calculating the total FTE number is your responsibility as an employer.
- Covered California cannot provide assistance with the FTE calculation. Please consult with a Certified Insurance Agent or visit the IRS website for assistance.

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## STEP 4 ) Select one plan level to offer to your employees.

Bronze     Silver     Gold     Platinum

**OR, you may offer your employees the opportunity to select from two plan levels:**

Bronze/Silver     Silver/Gold     Gold/Platinum

## STEP 5 ) Select reference plan within your selected plan level(s). (The reference plan is the plan you choose to determine the amount you will contribute toward your employee premiums.)

Health Insurance Carrier \_\_\_\_\_

Reference Plan Name (be as specific as possible) \_\_\_\_\_

In Plan Level     Bronze     Silver     Gold     Platinum

## STEP 6 ) Specify premium contribution.

**Enter the percentage amount you will contribute toward:**

Employee premium \_\_\_\_\_ % (50% minimum)

Dependent premium \_\_\_\_\_ % (optional, enter "0" if no contribution)

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# STEP 7 ) Certification — read & sign

**To participate in Covered California for Small Business, you must attest to the following:**

- A. I am signing this application under penalty of perjury, which means I have 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.
- B. I understand that the information I provided on this form will only be used to determine eligibility for and to facilitate enrollment in health coverage and will be kept private as required by federal and state law.
- C. My waiting period is in compliance with 42 U.S.C. § 300gg-7, Section 10198.7(c) of the California Insurance Code, as amended by Statutes 2013-2014, 1st Ex. Sess., ch. 1, § 7 and Section 1357.51(c) of the California Health and Safety Code, as amended by Statutes 2013-2014, 1st Ex. Sess., ch. 2, § 2, and all of my qualified employees have complied with the waiting period;
- D. If my employer roster is included, I have consent from everyone I have listed on this application to include their personally identifiable information, including but not limited to dates of birth, Social Security or tax identification numbers, addresses, and phone numbers.
- E. I know that under federal law, discrimination is not permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, disability, religion, marital status or veteran status.
- F. I know that that SHOP will not consider my group coverage approved until SHOP has received 100 percent of the first month's premium payment.
- G. I know that I must continue to make the required premium payments to continue to be an eligible employer in SHOP.
- H. I know that I must inform all eligible employees of the availability of coverage and that those not electing coverage must wait one year or experience a qualifying event to obtain coverage through my group plan if they later decide they would like to have coverage.
- I. I understand that once coverage is approved by SHOP, changes to the coverage cannot be implemented after my effective date until my next annual election of coverage period, except to the extent the qualified employer exercises the right to change coverage with the same issuer within the first 30 days of the effective date of coverage pursuant to Health and Safety Code 1357.504 (c) and the Insurance Code Section 10753.06.5 (c).
- J. I understand that health insurance coverage through the SHOP is subject to the applicable terms and conditions of the QHP issuer contract or policy and applicable state law, which will determine the procedures, exclusions and limitations relating to the coverage and will govern in the event of any conflict with SHOP or QHP issuer benefits comparison, summary or other description of coverage.
- K. I understand that once membership information is transmitted to the selected health plan issuers, group coverage effective dates cannot be changed nor can coverage be terminated until after the first month of coverage.
- L. I understand that the attestations in this section are subject to audit by SHOP at any time.
- M. I understand that the attestations in this section must be maintained in order for my group to continue coverage through SHOP.
- N. I certify that the total number of Full-Time Equivalent (FTE) employees that I have provided in box 7, page 2 of this application is true and correct to the best of my knowledge.

Signature of Business Owner/Authorized Company Officer	Title
Print Name	Date

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## STEP 8

### 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 9

### Did you...

- ...read the Full-Time Equivalent (FTE) employee guidance on page 3?
- ...read and sign page 5?
- ...attach all required documentation from page 1?
- ...complete the information for all eligible employees (if including an employee roster)?
- ...obtain your Certified Insurance Agent's signature?

**Note: Covered California will send you an invoice for your first month of premium.**

## STEP 10

### Mail the completed application & your employee applications.

Mail your completed application, including all employee applications and other required documents to:

**Covered California for Small Business  
P.O. Box 7010  
Newport Beach, CA 92658**

For overnight deliveries, send to:

**Covered California for Small Business Service Center  
15525 Sand Canyon Avenue  
Irvine, CA 92618**



### Need help?

If you have questions about this application or need help completing it, contact your Covered California Certified Insurance Agent, or call **(877) 453-9198**.

Para obtener una copia de este formulario en Español, llame **(877) 453-9198**.