Small Business Health Options Program (SHOP)

Application for employers

COVERED CALIFORNIA

Covered California's Small Business Health Options Program 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 50 eligible 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 complete an employee application and sign the appropriate section of the employee application.

Get help

- **Online: www.CoveredCA.com**
- **Phone:** Call our Service Center at **(877) 453-9198**
- **En Español:** Llame a nuestro centro de ayuda gratis al **(877) 453-9198**
- Contact your Insurance Agent
- Contact the SHOP Service Center for information on how to find a Covered California 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.

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)
☐ **Sole Proprietor**	☐ Less than 3 months	☐ Local Business License or ☐ Fictitious Business Name Filing	☐ DE-9C or ☐ Payroll Records for 30 Days	
	☐ 3 months or more	☐ Schedule C or ☐ Local Business License or Fictitious Business License	☐ DE-9C and ☐ Schedule C (if owner is enrolling)	
☐ **Corporation**	☐ Less than 3 months	☐ Articles of Incorporation (Filed and Stamped)	☐ DE-9C or ☐ Payroll Records for 30 Days	☐ Statement of Information (if Officers are offered coverage and not listed on DE-9C) or ☐ Corporate Meeting minutes listing all officers names
	☐ 3 months or more	☐ DE-9C	☐ Statement of Information (if Officers are offered coverage and not listed on DE-9C)	
☐ **Partnership**	☐ Less than 3 months	☐ Partnership Agreement	☐ Federal Tax ID Appointment letter	☐ DE-9C or ☐ Payroll records for 30 days
	☐ 3 months or more	☐ DE-9C	☐ Current Schedule K-1 (if Partners are not listed on DE-9C) or ☐ Partnership Agreement and Fed Tax ID Appointment letter (if Schedule K-1 not available yet)	
☐ **Limited Partnership (LP)**	☐ Less than 3 months	☐ Partnership Agreement	☐ Federal Tax ID Appointment letter	☐ DE-9C or ☐ Payroll records for 30 days
	☐ 3 months or more	☐ DE-9C (Limited Partners of a LP are not eligible for coverage unless they appear on a DE-9C)	☐ Current Schedule K-1 (if General Partners are not listed on DE-9C) or ☐ Partnership Agreement and Fed Tax ID Appointment letter (if Schedule K-1 not available yet)	
☐ **Limited Liability Partnership (LLP)**	☐ Less than 3 months	☐ Partnership Agreement or ☐ Federal Tax ID Appointment letter	☐ DE-9C or ☐ Payroll Records for 30 Days	
	☐ 3 months or more	☐ DE-9C	☐ Current Schedule K-1 (if Partners are not listed on DE-9C) or ☐ Partnership Agreement and Fed Tax ID Appointment letter (if Schedule K-1 not available yet)	
☐ **Limited Liability Company (LLC)**	☐ Less than 3 months	☐ Articles of Organization with Operating Agreement or ☐ Statement of information	☐ DE-9C or ☐ Payroll Records for 30 Days	
	☐ 3 months or more	☐ DE-9C	☐ 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 ☐ 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 the employer offering coverage.

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? ☐ Business legal name ☐ DBA
6. Organization type ☐ Private ☐ Nonprofit ☐ Government ☐ Church/church affiliated
7. Total number of employees on payroll?
8. Total number of eligible employees?
9. Requested Coverage Effective Date
10. SIC code
11. ☐ Yes, I'm offering dependent health coverage. *(See Step 7 to indicate optional employer contribution.)* ☐ No, I'm not offering dependent health coverage
12. ☐ Yes, I'm offering coverage to non-registered domestic partners. ☐ No, I'm not offering coverage to non-registered domestic partners.
13. My company is subject to: ☐ Federal COBRA ☐ Cal-COBRA
14. Have you employed 20 or more employees for 20 or more weeks during the current or preceding calendar year? ☐ Yes ☐ 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? ☐ Mail ☐ Email ☐ 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? ☐ Yes ☐ No
16. Is your billing address the same as your California business address? ☐ Yes ☐ 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 ☐ Yes ☐ No

NEED HELP WITH YOUR APPLICATION? Contact your agent with questions – visit **www.CoveredCA.com**, or call us at **(877) 453-9198**.

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STEP 4

List all employees who will be eligible for coverage (even if they may not enroll).

Note: If you will be including your employees' applications with your employer application, you may skip to Step 5.

You must include all full-time employees (average of 30+ hours per week, and part-time employees working 20-29 hours per week if offered coverage). You may photocopy this blank page and attach additional sheets as necesary.

EMPLOYEE

Last Name _____ Suffix _____

Tax ID or SSN _____

First Name _____

Middle Name _____

Date of Birth _____ COBRA/CAL-COBRA? Y / N

Home Street Address _____

City_____County _____ State _____ Zip Code _____

Spouse/Partner? Y / N* Spouse/Partner Date of Birth* _____

No. of Child Dependents Under 21* _____ No. of Child Dependents Age 21-25* _____

EMPLOYEE

Last Name _____ Suffix _____

Tax ID or SSN _____

First Name _____

Middle Name _____

Date of Birth _____ COBRA/CAL-COBRA? Y / N

Home Street Address _____

City_____County _____ State _____ Zip Code _____

Spouse/Partner? Y / N* Spouse/Partner Date of Birth* _____

No. of Child Dependents Under 21* _____ No. of Child Dependents Age 21-25* _____

EMPLOYEE

Last Name _____ Suffix _____

Tax ID or SSN _____

First Name _____

Middle Name _____

Date of Birth _____ COBRA/CAL-COBRA? Y / N

Home Street Address _____

City_____County _____ State _____ Zip Code _____

Spouse/Partner? Y / N* Spouse/Partner Date of Birth* _____

No. of Child Dependents Under 21* _____ No. of Child Dependents Age 21-25* _____

*** Spouse/partner and dependent information required only if employee chooses to enroll them for coverage.**

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STEP 5 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 6 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 7 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 8 Certification — read & sign

To participate in SHOP, 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 employee roster is included, I have consent from everyone I have listed on this application to include their personally identifiable information, like 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 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 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.

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

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STEP 9

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 10

Did you...

☐ **...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 11

Mail the completed application & your employee applications.

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

Covered California
P.O. Box 7010
Newport Beach, CA 92658

For overnight deliveries, send to:

Covered California SHOP Service Center
17620 Fitch St.
Irvine, CA 92614

Need help?

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

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