Covered California for Small Business (CCSB)

Application for Employees

COVERED CALIFORNIA
SMALL BUSINESS

ATTENTION! If you are already enrolled on a CCSB plan, please use the Employee Change Request Form to update, change, or terminate your existing CCSB coverage.

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 (855) 777-6782
- **En Español:** Llame a nuestro centro de ayuda gratis al (855) 777-6782

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 9.12% 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 are eligible to enroll in a Covered California for Small Business plan.

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 (855) 777-6782. Para obtener una copia de este formulario en Español, llame (855) 777-6782.

Who is your employer?

Employer Name

Employer phone number
( ) –

STEP 1 Information about you, the employee.

1. First name, Middle name, Last name, & Suffix	2. Requested Coverage Effective Date	3. Are you a new hire? ☐ Yes ☐ No
4. Social Security Number or Tax ID Number	5. Date of birth (mm/dd/yyyy)	

6. Home address			7. Apartment or suite number
8. City	9. State	10. ZIP code	11. County
12. Mailing address (if different from home address)			13. Apartment or suite number
14. City	15. State	16. ZIP code	17. County

18. Email address

19. Phone number ☐ Cell ☐ Home ☐ Work ( ) –	20. Other phone number ☐ Cell ☐ Home ☐ Work ( ) –
21. Cal-COBRA/COBRA Applicants: ☐ Cal-COBRA ☐ COBRA Cal-COBRA/COBRA effective date: _____ (Cal-COBRA applicants must submit first month's premium)	22. 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: _____
23. Marital Status: ☐ Single ☐ Married ☐ Domestic Partnership (DP)	

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

25. 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.

26. 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

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

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

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

Not interested in CCSB health coverage?

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

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continued on next page ➡

STEP 2

Please tell us about yourself and your eligible enrolling dependents and indicate your CCSB 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	☐ HEALTH PLAN **(See Appendix A)**	☐ DENTAL PLAN **(See Appendix A)**		
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 **(See Appendix A)**	
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 **(See Appendix A)**		
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 **(See Appendix A)**		
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 **(See Appendix A)**		

**If you have more than 3 dependent children, please attach a separate sheet listing their required information and submit with this application. *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 binding 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 , for premises liability, relating to the coverage for, or delivery of, services or items, or, if I select a Kaiser Permanente 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), 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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STEP 6

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

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

- ☐ Self
- ☐ Spouse/Domestic Partner
- ☐ Child(ren) Name(s) _____

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

- ☐ Self
- ☐ Spouse/Domestic Partner
- ☐ Child(ren) Name(s) _____

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 want to contact Covered California at www.coveredca.com for help in understanding available options and financial assistance in the Covered California Individual Marketplace)
- ☐ Covered by Medicare
- ☐ Covered by Medi-Cal
- ☐ Covered by other: _____

I acknowledge that the coverage available to me has been explained to me by my employer and I have the right to enroll in the coverage offered. I have voluntarily decided not to enroll myself and/or my eligible dependent(s). By declining this coverage I acknowledge that I and/or my eligible dependents will have to wait until my employer's next open enrollment period to enroll or change coverage, unless eligible for a special enrollment period through a qualifying event.

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).

NEED HELP WITH YOUR APPLICATION?

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Employee Name	Employer Name

APPENDIX A

Health and Dental Plan Choices

Important: Please select ONE benefit plan from Medical and/or Dental Choices by filling in the oval ⬭ next to the selected plan(s).

NOTE: Infertility benefits are available to employer groups when an Employer elects to provide this benefit during open enrollment or renewal periods. If an employer with 20 or more full time employees elects to provide infertility benefits, all plans offered will include this coverage. If an employer with less than 20 full time employees elects to provide infertility benefits, only PPO and EPO plans will include this coverage. Infertility benefits will not be included in HMO plans for groups with less than 20 full time employees.

	Metal Tier			
Health Plan	**Bronze**	**Silver**	**Gold**	**Platinum**
Blue Shield of California	☐ Bronze 60 PPO 6300/65+ Child Dental	☐ Silver 70 PPO 2500/55 + Child Dental ☐ Trio Silver 70 HMO 2500/55 + Child Dental	☐ Gold 80 PPO 350/25 + Child Dental ☐ Trio Gold 80 HMO 250/35 + Child Dental	☐ Platinum 90 PPO 0/15 + Child Dental ☐ Trio Platinum 90 HMO 0/20 + Child Dental
Kaiser Permanente	☐ Bronze 60 HMO 6300/65 +Child Dental ☐ Bronze 60 HMO 5400/60 + Child Dental Alt ☐ Bronze 60 HDHP HMO 7000/0% + Child Dental	☐ Silver 70 HMO 2500/55 + Child Dental ☐ Silver 70 HDHP HMO 2700/25% + Child Dental ☐ Silver 70 HMO 1900/65 + Child Dental Alt ☐ Silver 70 HMO 2300/65 + Child Dental Alt ☐ Silver 70 HMO 2800/65 + Child Dental Alt	☐ Gold 80 HMO 250/35 + Child Dental ☐ Gold 80 HMO 1000/40 + Child Dental Alt ☐ Gold 80 HMO 0/30 + Child Dental Alt ☐ Gold 80 HDHP HMO 1600/15% + Child Dental Alt	☐ Platinum 90 HMO 0/10 + Child Dental Alt ☐ Platinum 90 HMO 0/20 + Child Dental
Sharp	☐ Performance Bronze 60 HMO 6300/65 + Child Dental ☐ Premier Bronze 60 HDHP HMO 7000/0% + Child Dental	☐ Premier Silver 70 HMO 2500/55 + Child Dental ☐ Performance Silver 70 HMO 2500/55 + Child Dental ☐ Premier Silver 70 HDHP HMO 2700/25% + Child Dental	☐ Performance Gold 80 HMO 350/25 + Child Dental ☐ Premier Gold 80 HMO 250/35 + Child Dental	☐ Performance Platinum 90 HMO 0/15 + Child Dental ☐ Premier Platinum 90 HMO 0/20 + Child Dental

* For health plans that do not include Child Dental, employees have the option to elect a standalone pediatric dental plan. Dependant children are eligible for Pediatric Dental coverage up to age 19.

Dental Plan	**Pediatric Dental Plans**	**Family Dental Plans ****
California Dental Network	☐ Children's Dental HMO	☐ Family Dental HMO
Delta Dental	☐ Children's Dental HMO ☐ Children's Dental PPO	☐ Family Dental HMO ☐ Family Dental PPO
Dental Health Services		☐ Family Dental HMO

** Family dental plans offer both adult only and adult plus child coverage.