

Employer name

CCSB Group #

PLEASE COMPLETE ONLY THE INFORMATION THAT HAS CHANGED

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

Check here if there are NO Changes

1. First name, Last name, & Suffix

2. Phone number
() -

3. Email address (OPTIONAL)

4. Do you want to go paperless?
 Yes No

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

Agent Information (if applicable)

LIST ANY EMPLOYEES YOU ARE TERMINATING FROM COVERAGE AND INDICATE REASON

EMPLOYEE INFORMATION CHANGES: To *change* employee information or coverage such as adding a dependent or changing a home address, please attach a completed Change Request Form for Employees.

EMPLOYEE LAST NAME	FIRST NAME	MI	SSN / TAX ID #
REASON <input type="checkbox"/> Waive Coverage <input type="checkbox"/> Reduction of Hours	<input type="checkbox"/> Too Expensive <input type="checkbox"/> Termination with cause	<input type="checkbox"/> Death <input type="checkbox"/> Separation/Divorce	LAST DAY OF COVERAGE
EMPLOYEE LAST NAME	FIRST NAME	MI	SSN / TAX ID #
REASON <input type="checkbox"/> Waive Coverage <input type="checkbox"/> Reduction of Hours	<input type="checkbox"/> Too Expensive <input type="checkbox"/> Termination with cause	<input type="checkbox"/> Death <input type="checkbox"/> Separation/Divorce	LAST DAY OF COVERAGE
EMPLOYEE LAST NAME	FIRST NAME	MI	SSN / TAX ID #
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EMPLOYEE LAST NAME	FIRST NAME	MI	SSN / TAX ID #
REASON <input type="checkbox"/> Waive Coverage <input type="checkbox"/> Reduction of Hours	<input type="checkbox"/> Too Expensive <input type="checkbox"/> Termination with cause	<input type="checkbox"/> Death <input type="checkbox"/> Separation/Divorce	LAST DAY OF COVERAGE

? **NEED HELP WITH THIS FORM?** Contact your Covered California Certified Insurance Agent with questions, visit **CoveredCA.com** or call us at **(855) 777-6782**. Para obtener una copia de este formulario en Español, llame **(855) 777-6782**.

CHANGE PLAN LEVELS OFFERED TO YOUR EMPLOYEES (IF APPLICABLE)**PLEASE NOTE:** Plan levels may be changed only at renewal.

1 Metal Tier Plan Level Bronze Silver Gold Platinum

2 Metal Tiers: You may offer your employees the option to select from touching plan levels as indicated below:

2 Metal Tier Plan Level Bronze + Silver Silver + Gold Gold + Platinum

3 Metal Tiers: You may offer your employees the option to select from touching plan levels as indicated below:

3 Metal Tier Plan Level Bronze + Silver + Gold Silver + Gold + Platinum

4 Metal Tiers: You may offer your employees the option to select from touching plan levels as indicated below:

4 Metal Tier Plan Level Bronze + Silver + Gold + Platinum

CHANGE YOUR REFERENCE PLAN (IF APPLICABLE)**PLEASE NOTE:** Reference Plans may be changed only at renewal.**NEW Reference Plan**

Health Carrier _____
 Plan Name _____
 Plan Level _____

CHANGE YOUR PREMIUM CONTRIBUTION (IF APPLICABLE)**PLEASE NOTE:** Premium contributions may be changed only at renewal.**NEW Contribution Level**

Employee premium _____% (50% minimum)
 Dependent premium _____% (optional, enter "0" if no contribution)

INFERTILITY

Do you want to offer plans that include infertility coverage?

 Yes No**Employers with 20 or more FTE's:**

- Employers with 20 or more full-time equivalent (FTE) employees who choose to offer Infertility benefits to their employees, all products shall include Infertility benefits.
- Employers with 20 or more FTE employees who choose to not offer Infertility benefits to their employees, all products shall not include Infertility benefits.

Employers with less than 20 FTE's:

- Employers with less than 20 FTE employees have the option to include Infertility benefits only on Non-HMO plans.

If Employer chooses to offer Infertility benefits, the following applies:

- Employees selecting an HMO product cannot select a plan with Infertility benefits.
- Employees selecting either a PPO or EPO product must select a plan with Infertility benefits.

If Employer chooses to not offer Infertility benefits, the following applies:

- Employees electing an HMO product cannot select a plan with Infertility benefits.
- Employees electing either a PPO or EPO product cannot select a plan with Infertility benefits.

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DENTAL COVERAGE

Do you want to offer dental coverage? Yes No

CHANGE YOUR DENTAL REFERENCE PLAN (IF APPLICABLE)

PLEASE NOTE: Dental Reference Plans may be changed only at renewal.

NEW Reference Plan

Dental Carrier	_____
Plan Name	_____
Plan Level	_____

CHANGE YOUR DENTAL PREMIUM CONTRIBUTION (IF APPLICABLE)

PLEASE NOTE: Dental Premium contributions may be changed only at renewal.

NEW Contribution Level

Employee premium	_____ % (optional, enter "0" if no contribution)
Dependent premium	_____ % (optional, enter "0" if no contribution)

CERTIFIED INSURANCE AGENT INFORMATION

Please tell us the Certified Insurance Agent who assisted you with your Covered California for Small Business health coverage.

Certified Insurance Agent Name	Email	Phone Number
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I did not receive assistance from a Certified Insurance Agent.

ATTESTATION, ARBITRATION – read, complete & sign.**To participate in Covered California for Small Business, you must attest to the following:**

- A.) 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.
- B.) 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;
- C.) If my employee 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.
- D.) 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.
- E.) I know that SHOP will not consider my group coverage approved until the initial invoice has been paid in full and delivered to the SHOP or postmarked by the due date indicated on the invoice.
- F.) I know that I must continue to make the required payments of the total balance due by the due date on the invoice, to continue to be an eligible employer in SHOP.
- G.) 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.
- H.) I understand that once coverage is approved by CCSB, 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).
- I.) I understand that health insurance coverage through the CCSB 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 CCSB or QHP issuer benefits comparison, summary or other description of coverage.
- J.) 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.
- K.) I understand that the attestations in this section are subject to audit by CCSB at any time.
- L.) I understand that the attestations in this section must be maintained in order for my group to continue coverage through CCSB.
- M.) 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.

I have read and attest to the foregoing requirements for participation in CCSB.

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.

I have read and agree to the Binding Arbitration Agreement


SIGN THE FORM AND SEND TO COVERED CALIFORNIA

Signature of Business Owner/Authorized Company Officer

Title

Print Name

Date

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