Covered California for Small Business (CCSB)

ENROLLMENT APPLICATION FOR EMPLOYERS

COVERED CALIFORNIA | Small Business

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

Who can use this application?

To be eligible to participate in CCSB, you must indicate that your business or organization meets all of these qualifications:

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

What you will need to apply

- 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.

Acceptable verification options for 3+ enrolling employees

- Submit most recent DE-9C,
- Submit payroll records for the past 30 days (if in business for less than 3 months), **or**
- (**New**) If previously insured, provide prior coverage documentation from the previous insurance carrier as an alternative to the DE-9C. If qualified employees are not listed on the prior coverage documentation, a DE-9C or payroll records for 30 days are required.

Get help

- **Online: www.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**
- Contact your Insurance Agent
- Contact the Covered California for Small Business Service Center for information on how to find an Insurance Agent (855) 777-6782

What happens next?

You'll send this form and your employees' completed, signed applications to the address on page 7. 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 CCSB 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 CCSB

You must provide a document from each group for your business type.

You are a:	And have been in business for:	You must provide the following:		
		Document Group 1 (Choose one)	**Document Group 2 (Choose one)**	**Document Group 3 (Choose one)**
☐ **Sole Proprietor** Sole Proprietors are eligible for coverage through CCSB if they have eligible employees	☐ Less than 3 months	☐ Local Business License or ☐ Fictitious Business Name Filing	☐ DE-9C or ☐ Payroll Records for 30 Days or ☐ Prior Carrier Bill (For Employers with 3+ Enrolling Employees)	
	☐ 3 months or more	☐ 3 months or more or ☐ Local Business License or Fictitious Business License	☐ DE-9C or ☐ Prior Carrier Bill (For Employers with 3+ Enrolling Employees) 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 or ☐ Prior Carrier Bill (For Employers with 3+ Enrolling Employees)	☐ 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 or ☐ Prior Carrier Bill (For Employers with 3+ Enrolling Employees)	☐ 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 or ☐ Prior Carrier Bill (For Employers with 3+ Enrolling Employees)
	☐ 3 months or more	☐ DE-9C or ☐ Prior Carrier Bill (For Employers with 3+ Enrolling Employees)	☐ 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 or ☐ Federal Tax ID Appointment letter	☐ Federal Tax ID Appointment letter	☐ DE-9C or ☐ Payroll Records for 30 Days or ☐ Prior Carrier Bill (For Employers with 3+ Enrolling Employees)
	☐ 3 months or more	☐ DE-9C (Limited Partners of a LP are not eligible for coverage unless they appear on a DE-9C) or ☐ Prior Carrier Bill (For Employers with 3+ Enrolling Employees)	☐ 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 or ☐ Prior Carrier Bill (For Employers with 3+ Enrolling Employees)	
	☐ 3 months or more	☐ DE-9C or ☐ Prior Carrier Bill (For Employers with 3+ Enrolling Employees)	☐ 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 or ☐ Prior Carrier Bill (For Employers with 3+ Enrolling Employees)	
	☐ 3 months or more	☐ DE-9C or ☐ Prior Carrier Bill (For Employers with 3+ Enrolling Employees)	☐ 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 your business.

Employers must have a primary business address in California, or offer coverage to each eligible employee through CCSB servicing that employee's primary worksite.

1. Business legal name	Preferred Name ☐	2. Federal Employer Identification Number (FEIN)
3. Doing business as (DBA)	Preferred Name ☐	4. State Employer Identification Number (SEIN)
5. Organization type ☐ Private ☐ Nonprofit ☐ Government ☐ Church/church affilliated		6. Total number of Full-Time Equivalent (FTE) employees*?
7. Total number of eligible employees?	8. Requested Date for Coverage to Begin	9. SIC code
10. I'm offering health coverage to:** ☐ Employee Only ☐ Employee + Family	11. ☐ Yes, I'm offering coverage to non-registered domestic partners. ☐ No, I'm not offering coverage to non-registered domestic partners.	
12. My company is subject to: ☐ Federal COBRA (20 or more FTE) ☐ Cal-COBRA (19 or less FTE)	13. Have you employed 20 or more employees for 20 or more weeks during the current or preceding calendar year? ☐ Yes ☐ No	
14a. Do you currently offer health coverage? ☐ Yes ☐ No	14b. If yes, with which Health Insurance Company?	15. Do you intend to take advantage of the Small Business Health Care Tax Credit? ☐ Yes ☐ No ☐ Not Eligible

STEP 3 Tell us who to contact about this application or change.

Primary Contact (official communications will be addressed to the primary contact)				
1. First name, Last name, & Suffix				
2. Phone number		3. Email address		
4. Do you prefer paperless communication? ☐ 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		
Company Addresses				
9. Principal 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 principal business address? ☐ Yes ☐ No		16. Is your billing address the same as your principal business address? ☐ Yes ☐ No		
17. Mailing address	18. City	19. State	20. ZIP Code	21. County
Agent Information (if applicable)				
1. First name, Middle name, Last name, & Suffix		2. CA insurance license #		3. Agency FEIN #
4. Covered California Insurance Agent	☐ Yes ☐ No			
5. General Agency name (if applicable)				

* Please refer to page 3 for more information regarding Full-Time Equivalent (FTE) employees and how to arrive at this calculation.
** If an employer is considered as an Applicable Large Employer (ALE) (total of 50 or more FTE employees), the employer will need to offer dependent children coverage to their employees in order to avoid the Employer Shared Responsibility (ESR) penalties. Please refer to Section 4980H of the Internal Revenue Code

NEED HELP WITH YOUR APPLICATION? Contact your Insurance Agent with questions – visit **www.CoveredCA.com**, or call us at **(855) 777-6782**.

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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 Employer Shared Responsibility Provisions (ESRP) 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. See Health and Safety Code Section 1357.500(k)(3) and Insurance Code Section 10965.3(q)(3) 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 ESRP, 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. Information on how to perform the FTE calculation can be found using the Employer Shared Responsibility Provisions https://www.irs.gov/affordable-care-act/employers/employer-shared-responsibility-provisions
2. Use the final FTE figures as the number you use to fill in Step 2, question 7 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. 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 an Insurance Agent or visit the IRS website for assistance.

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STEP 4 Select a metal tier option to offer to your employees.

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

☐ Check here if you are changing your plan level.

4 Metal Tier

Employees choose from health plans in **all four metal tiers:**



☐

3 Metal Tier

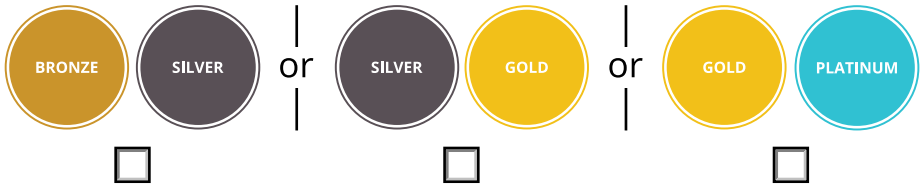
Employees choose from health plans in the **three touching metal tiers:**



☐ ☐

2 Metal Tier

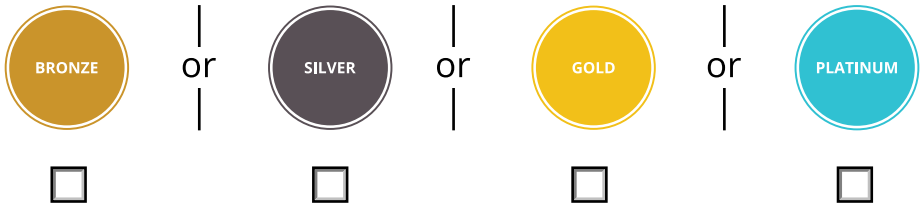
Employees choose from health plans in the **two touching metal tiers:**



☐ ☐ ☐

1 Metal Tier

Employees choose from health plans in the **one metal tier:**



☐ ☐ ☐ ☐

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 monthly premiums.)

Health Insurance Company _____

Reference Plan Name (be as specific as possible) _____

In Plan Level ☐ Bronze ☐ Silver ☐ Gold ☐ Platinum

STEP 6 Specify monthly premium contribution.

Enter the percentage amount you will contribute toward:

Employee monthly premium _____ % (50% minimum)

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

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STEP 7 Infertility

Do you want to offer coverage plans that includes infertility coverage?** ☐ Yes ☐ No

See below for rules about infertility coverage offerings:

All employers have the option to offer infertility coverage as part of their health insurance. If an employer chooses to offer infertility benefits to their employees, all health insurance plans available will include infertility benefits. If an employer chooses not to offer infertility coverage to their employees, the health insurance plans available to their employees will not include infertility benefits.

******Employers who do not select an answer, will default to **No** – agreeing that they do not wish to offer coverage plans that include infertility.

STEP 8 Dental Coverage

Do you want to offer dental coverage? ☐ Yes ☐ No

STEP 9 Select reference dental 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 monthly premiums.)

Dental Insurance Company _____

Reference Plan Name
(be as specific as possible) _____

STEP 10 Specify *dental* monthly premium contribution *(optional).*

Enter the percentage amount you will contribute toward:

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

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

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STEP 11 Attestation, Arbitration & Signature – 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 major life change 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 SHOP, changes to the coverage cannot be implemented after the date my coverage begins 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 the coverage begins 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 SHOP is subject to the applicable terms and conditions of the health insurance company 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 health insurance company benefits comparison, summary or other description of coverage.

J. I understand that once membership information is transmitted to the selected health insurance company, the date coverage begins for the group cannot be changed nor can the coverage be ended until after the first month of coverage.

K. I understand that the attestations in this section are subject to audit by SHOP at any time.

L. I understand that the attestations in this section must be maintained in order for my group to continue coverage through SHOP.

M. I certify that the total number of Full-Time Equivalent (FTE) employees that I have provided in box 7, Step 2 of this application is true and correct to the best of my knowledge.

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 attest to the foregoing requirements A-M (above) for participation in CCSB.**

☐ **I have read and agree to the Binding Arbitration Agreement**

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

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STEP 12 If an Insurance Agent helped you complete this application, please obtain their signature below.

☐ **I did not use an 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 signed by me is false, I may be subject to civil penalties of up to $10,000 as authorized under the Insurance Code Section 10119.3 or up to $20,000 under the Health and Safety Code Section 1389.8 as well as any applicable penalties or remedies under current law.**

Signature of Insurance Agent	
Print Name	Date

STEP 13 Did you...

- ☐ **...read the Full-Time Equivalent (FTE) employee guidance on page 3?**
- ☐ **...read and sign page 6?**
- ☐ **...attach all required documentation from Step 1?**
- ☐ **...complete the information for all eligible employees (if including an employee roster)?**
- ☐ **...obtain your Insurance Agent's signature?**

Note: Covered California will send you an invoice for your first month's premium.

STEP 14 Submit your completed application and your employee applications.

Completed application, including all employee applications and other required documents to:

Email: ccsbeligibility@covered.ca.gov

Fax: (949) 809-3264

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



Need help?

If you have questions about this application or need help completing it, contact your Covered California Insurance Agent, or call (855) 777-6782.

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