Form Approved
OMB No. 0938-1194

Small Business Health Options Program (SHOP)

Health coverage application for employees

Use this application to see if you're eligible to get SHOP health coverage from your employer. It should take about **10 minutes** to complete this application.

THINGS TO KNOW

Go online

Visit **HealthCare.gov**. You'll be able to see details about SHOP coverage in the Health Insurance Marketplace.

Get help

Ask your employer who to call with questions.

- **Online: HealthCare.gov**
- **Phone:** Call our Help Center at **1-800-318-2596**
- **En Español:** Llame a nuestro centro de ayuda gratis al **1-800-318-2596**

What happens next?

You'll return your completed, signed application to your employer. Your employer will send us your completed, signed application. We'll contact you with information about how to start a SHOP account, find out about costs and coverage, and enroll in a plan.

Alternatives

If your share of the cost of employee-only coverage is more than 9.5% of your household income, you may able to get help paying for coverage through the individual Health Insurance Marketplace. Visit **HealthCare.gov** to learn more.

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 you qualify for health coverage in the SHOP and to help you enroll.

NEED HELP WITH YOUR APPLICATION? Contact your employer's broker with questions, visit **HealthCare.gov**, or call us at 1-800-318-2596. TTY users should call 1-877-871-6594. Para obtener una copia de este formulario en Español, llame 1-800-318-2596.

Who is your employer?

Employer name & address

Employer phone number

( ) –

Get started with your application below.

Not interested in SHOP health coverage?

If you don't want SHOP health coverage from your employer, skip to Step 3 on page 2.

STEP 1 I'm interested in SHOP coverage from this employer.

Information about you, the employee.

1. First name, Middle name, Last name, & Suffix

2. Social Security number/Tax ID Number	3. Date of birth (mm/dd/yyyy)	4. Sex ☐ Male ☐ Female

5. Home address (leave blank if you don't have one)	6. Apartment or suite number

7. City	8. State	9. ZIP code	10. County

11. Mailing address (if different from home address)	12. Apartment or suite number

13. City	14. State	15. ZIP code	16. County

17. Email address

18. Phone number ☐ Cell ☐ Home ☐ Work ( ) –	19. Other phone number ☐ Cell ☐ Home ☐ Work ( ) –

20. Notices will be sent electronically. You must go to **HealthCare.gov** and create an online account to receive electronic notices.
☐ Check here if you also want to get paper notices by mail.

21. Preferred spoken or written language (if not English)

22. If Hispanic/Latino, ethnicity (OPTIONAL—Check all that apply.)

☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other

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

☐ White	☐ American Indian or Alaska Native	☐ Filipino	☐ Vietnamese	☐ Guamanian or Chamorro
☐ Black or African American	☐ Asian Indian	☐ Japanese	☐ Other Asian	☐ Samoan
	☐ Chinese	☐ Korean	☐ Native Hawaiian	☐ Other Pacific Islander
				☐ Other

24. If you're American Indian or Alaska Native, tell us the state and the name of your federally-recognized tribe

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STEP 2 Read & sign this application.

- I'm 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 the SHOP if anything changes (and is different than) what I wrote on this application. I can call my employer's agent or broker, visit **HealthCare.gov**, or call **1-800-318-2596** 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	Date (mm/dd/yyyy)

STEP 3 If you don't want SHOP coverage from this employer.

☐ **I don't want health coverage from this employer.** If this employer offers health coverage for my dependents, I decline that offer of coverage, too.

Answer these questions:

Do you have another source of health coverage? ☐ Yes ☐ No

If **yes**, what type?

☐ Individual private health insurance
☐ Insurance from another job
☐ Insurance through another person's job
☐ Medicare
☐ Medicaid
☐ Indian Health Service
☐ TRICARE
☐ VA health care programs

☐ **If this employer offers dental coverage, I don't want that coverage.** If this employer offers dental for my dependents, I decline that offer of coverage, too.

Employee name	
Signature	Date (mm/dd/yyyy)

STEP 4 Return your completed, signed application to your employer.

Your employer will send us your application, and you'll hear back from us with details about how to start a SHOP account, find out about costs and coverage, and enroll in a plan.

If you want to register to vote, you can complete a voter registration form at **XXXXX.gov**.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1194. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to:
CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Need help?

If you have questions about this application or need help completing it, contact your employer, your employer's agents or brokers, visit **HealthCare.gov**, or call us at **1-800-318-2596**.

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