Form Approved
OMB No. 0938-1193

Small Business Health Options Program (SHOP)

Health coverage application for employers

The SHOP Health Insurance Marketplace offers a new way for small employers to offer health insurance to employees. The SHOP is open to all small business owners. It should take about **15 minutes** to complete this application for eligibility.

THINGS TO KNOW

Who can use this application?

- Employers who cannot apply online.
- Employers not working with a broker.

Is my business eligible for the SHOP?

Your business or organization must:

- Have a primary business address within the state where you're buying coverage,
- Have at least one common-law employee,
- Have 50 or fewer full-time equivalent (FTE) employees,* and
- Offer coverage through the SHOP to all full-time employees

Apply faster online

- Visit **HealthCare.gov** to apply for SHOP online.
- Your coverage start date will be the first of the month at least 2 full months from the date the application is mailed. If you need coverage sooner, apply online.

Get help

- **Online: HealthCare.gov**
- **Phone:** Call our Help Center at **1-800-706-7893**
- **En Español:** Llame a nuestro centro de ayuda gratis al **1-800-706-7893**
- **Contact a broker:** Visit **HealthCare.gov** or call **1-800-706-7893**

What happens next?

You'll send this form and your employees' completed, signed applications to the address on page 3. 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 and give you the information you need to compare cost and coverage options, select a plan, and complete the enrollment process.

* Most states require 50 or fewer FTEs for the SHOP. To be eligible in some states, a business or organization can have 100 or fewer FTEs. Starting in 2016, all businesses and organizations with 100 or fewer FTEs will be eligible for the SHOP.

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 the SHOP and, if eligible, to facilitate enrollment.

NEED HELP WITH YOUR APPLICATION? Contact a broker with questions, visit **HealthCare.gov**, or call us at 1-800-706-7893. TTY users should call 1-800-706-7915. Para obtener una copia de este formulario en Español, llame 1-800-706-7893.

STEP 1 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).

NOTE: If you're using a broker to apply, you must apply online.

1. Employer name	2. Federal Employer Identification Number (EIN)
3. Doing business as	

4. Employer type ☐ Private sector (profit & non-profit) ☐ Church/church affiliated ☐ State/local government ☐ Foreign government ☐ Tribal government and tribally-owned or sponsored organizations and businesses

5. Primary business address

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

10. How many full-time equivalent employees?	11. ☐ **Yes, I'm offering health coverage to all full-time employees.**

STEP 2 Tell us who to contact about this application.

Primary contact

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

2. Title

3. Mailing address (if different from primary business address above)

4. City	5. State	6. ZIP code	7. County

8. Phone number ☐ Work ☐ Home ☐ Cell ( ) –	9. Other phone number ☐ Work ☐ Home ☐ Cell ( ) –
10. Fax number ( ) –	11. Email address

12. Notices and monthly invoices will be sent electronically. This person must visit **HealthCare.gov** and create an online account to receive electronic notices and invoices. ☐ Check here if this person also wants to get paper notices by mail.

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

Secondary contact (optional)

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

15. Title

16. Mailing address (if different from business address)

17. City	18. State	19. ZIP code	20. County

21. Phone number ☐ Work ☐ Home ☐ Cell ( ) –	22. Other phone number ☐ Work ☐ Home ☐ Cell ( ) –
23. Fax number ( ) –	24. Email address

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STEP 3 OPTIONAL

List all employees who'll get an offer of coverage even if they may not enroll.

You must include all full-time employees (30+ hours)

Employee first name, middle name, last name, & suffix	Date of birth (mm/dd/yyyy)	Social Security number/ Tax ID Number	Email address	Employment status*	Date of hire (mm/dd/yyyy)
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
15.					
16.					
17.					
18.					
19.					
20.					

*Enter employment status: full time, part time, owner/business partner, spouse of owner, COBRA, or retired

Attach more sheets as necessary.

STEP 4 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 my business or organization is eligible, this information will be used to facilitate enrollment.
- I know that I must tell the SHOP if anything changes (and is different than) what I wrote on this application. I can visit **HealthCare.gov** or call **1-800-706-7893** to report changes.
- I have consent from everyone I'll list on the application to include their personally identifiable information, like dates of birth, Social Security numbers, addresses, and phone numbers.
- 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 5 Mail the completed application & your employee applications.

Mail your completed application, **including all employee applications** to:

Health Insurance
1005 XYZ Drive
Washington, DC 20005

You'll hear back from us within 1 2 weeks. We'll let you know if you're eligible to buy coverage for your small business, and provide you with the information you need to compare cost and coverage options, select a plan, and complete the enrollment process.

NOTE: If you're using a broker, you must apply online.

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 0938-1193. The time required to complete this information collection is estimated to average 15 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 a broker, or call **1-800-706-7893**.

Para obtener una copia de este formulario en Español, llame **1-800-706-7893**.