Small Business Health Options Program (SHOP)

Health coverage application for employers

Maryland Health Connection's Small Business Health Options Program (SHOP) is open to all eligible small business owners. It should take about **15 minutes** to complete this application for eligibility.

THINGS TO KNOW

Is my business eligible for the SHOP?

Your business or organization must:

- Have a primary business address within Maryland,
- 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

Get help

- Online: **MarylandHealthConnection.gov.**
- Phone: Call our consumer support center at **1-855-642-8572.** TTY users should call **1-855-642-8573.**
- En Español: Llame a nuestro centro de asistencia al consumidor al **1-855-642-8572.** Los usuarios de TTY deben llamar al **1-855-642-8573.**
- Contact a broker.

What happens next?

You'll send this form to the address on page 3. 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.

You may also contact an insurance agent or broker or an insurance company with SHOP plans to begin the application and enrollment process. To see which companies offer SHOP plans in your area, go to **MarylandHealthConnection.gov.**

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.
- You can learn more about how we handle your information at **MarylandHealthConnection.gov**.

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STEP 1 Tell us about the employer offering coverage.

Employers must be located within Maryland and must offer coverage to all full-time employees (those working on average 30+ hours per week).

1. Marketplace User ID (optional) (Administrative use only)

2. Employer name* | 3. Federal Employer Identification Number (EIN)*

4. Doing business as

5. 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

6. Primary business address*

7. City* | 8. State* | 9. Zip Code*

10. To be eligible to participate in the SHOP, your business must:
- Have a primary business address within Maryland;
- 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.

☐ **I agree that all of the above apply to my business.***

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. Phone number* ☐ Work ☐ Home ☐ Cell | 8. Second phone number* ☐ Work ☐ Home ☐ Cell

9. Fax number | 10. Email address* | Re-enter email address*

11. Preferred language (if not English)

12. Note: Notices and monthly invoices will be sent by the carrier.

Secondary contact (optional)

13. First name* | Middle name | Last name* | Suffix

14. Title*

15. Mailing address* (if different from primary business address above)

16. City* | 17. State* | 18. Zip Code*

19. Phone number* ☐ Work ☐ Home ☐ Cell | 20. Second phone number* ☐ Work ☐ Home ☐ Cell

21. Fax number | 22. Email address* | Re-enter email address*

* Required Field

NEED HELP WITH YOUR APPLICATION? Contact a broker with questions, visit **MarylandHealthConnection.gov** or call us at **1-855-642-8572**. TTY users should call **1-855-642-8573**.

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STEP 3

For certified application counselors, navigators, agents, and brokers only.

Complete this section if you're a certified application counselor, navigator, agent, or broker filling out this application for somebody else.

1. First name	Middle name	Last name	Suffix

2. Organization name (if applicable)	3. ID number, if applicable (NPN for brokers)

4. Phone number ☐ Work ☐ Home ☐ Cell	5. Second phone number ☐ Work ☐ Home ☐ Cell

6. Fax number	7. Email address	Re-enter email address

STEP 4

List all employees who'll get an offer of coverage even if they may not enroll. Include owners and business partners.

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

	Employee first name*	Middle name	Last name*	Suffix	Date of birth (mm/dd/yyyy)* (If available)	Social Security/ Tax ID Number* (If available)	Employment status*	Date of hire (mm/dd/yyyy)	Average weekly hours if not full time
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									

* Required Field

☐ Attach more sheets as necessary. You may attach your own spreadsheet with the information requested in Step 4 instead of using this document to provide that information.

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STEP 5 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 state and 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 **MarylandHealthConnection.gov** or call **1-855-642-8572** (TTY users: **1-855-642-8573**) 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 state and 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** or **www.mccr.maryland.gov/intake.html.**

Name of person signing*

Signature* | Date(mm/dd/yyyy)*

* Required Field

STEP 6 Mail the completed application.

Mail your completed application to:

Group Benefit Services, Inc.
c/o Maryland Health Connection
6 North Park Drive, Suite 310
Hunt Valley, Maryland 21030

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.

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 12.57 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 **1-855-642-8572.** TTY users should call **1-855-642-8573.**

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Privacy Statement

In addition to collecting business information on the Maryland Health Connection Small Business Health Options Program (SHOP) Employer Application form, we are authorized, under the Patient Protection and Affordable Care Act (Public Law No.111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law No. 111-152), to collect personally identifiable information and any supporting documentation that might be required for processing this application, including the name and contact information (email address, home address, home phone number, date of birth and Social Security number) for a primary and secondary employer contact, and the names, Social Security numbers and dates of birth of all full-time employees.

We need the information provided by you about primary and secondary employer contacts and the full-time employees listed on this form to determine whether you are a qualified employer and your employees are qualified employees to facilitate enrollment in a qualified health plan (QHP) through the SHOP. As part of that process, we will verify the information provided on the form, communicate with your primary and/or secondary employer contacts and any Agent, Broker or other SHOP assister that may have assisted you with your SHOP application, and eventually provide the information to the health plan selected so that qualified employees can enroll in a (QHP). We will also use the information provided as part of the ongoing operation of the SHOP, including activities such as verifying continued eligibility, reporting on and managing enrollment for qualified employees, performing oversight and quality control activities, combatting fraud, and responding to any concerns about the security or confidentiality of the information.

While providing the requested information (including Social Security numbers) is voluntary, failing to provide it may delay or prevent your ability to obtain health coverage through the SHOP. If an individual does not maintain qualifying health coverage for three months or longer during the year, that individual may be subject to a penalty.

If you don't provide correct information on this form or knowingly and willfully provide false or fraudulent information, you may be subject to a penalty and other law enforcement action. In order to verify and process application forms, determine whether you are a qualified employer and if your employees are eligible to participate, and to operate the SHOP, we may need to share selected information that we receive from you on the Maryland Health Connection SHOP Employer Application form outside of Maryland Health Connection, including with:

1. Federal agencies, (i.e., the Internal Revenue Service) to report eligibility for health insurance coverage through the SHOP,

2. Maryland Health Connection contractors engaged to perform a function for the SHOP and other contractors engaged to perform verification including those conducting verification of the employer's primary and secondary contacts' identity and other consumer reporting agencies,

3. Agents, Brokers and other SHOP assisters, and issuers of QHPs as applicable, who have been engaged to assist with eligibility determinations and enrollment in QHPs, and

4. Anyone else as required by law.

You can learn more about how we handle your information at http://marylandhealthconnection.gov/internet-policies-fraud/.