Covered California for Small Business (CCSB)

Enrollment and Change Request for Employees

COVERED CALIFORNIA
SMALL BUSINESS

THINGS TO KNOW

Go online

Visit **CoveredCA.com/ForSmallBusiness**. You'll be able to see details about Covered California's small business health insurance marketplace.

Get help

- **Ask your employer who to call with questions**
- **Online: 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

What happens next?

You'll return your completed, signed application to your employer. Your employer will send us your completed, signed application.

Alternatives

If your share of the cost of employee-only coverage is more than 8.39% of your household income, you may able to get help paying for coverage through Covered California's individual marketplace. Visit **CoveredCA.com** to learn more.

Your information is private.

- We'll keep your information private as required by law.
- Your answers on this application will only be used to see if you are eligible to enroll in a Covered California for Small Business plan.

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

To be Completed by the Employer:

Requested Effective Date:

Employer Group Name:

Employer Group Number
(for existing employer group):

Email completed form to ccsbeligibility@covered.ca.gov
Fax completed form to (949) 809-3264
Mail to Covered California at P.O. Box 7010, Newport Beach, CA 92658
For assistance call (855) 777-6782

STEP 1 Reason for Enrollment and Change Request:

				Effective Date MM/DD/YYYY	Qualifying Event Date
☐	New Enrollment		EFFECTIVE AT GROUPS COVERAGE EFFECTIVE DATE		
☐	Group Open Enrollment		MUST BE RECEIVED PRIOR TO RENEWAL DATE		
☐	New Hire / Employment Change		INDICATE EFFECTIVE DATE AND QUALIFYING LIFE EVENT DATE		
☐	Loss/Gain of Other Coverage				
☐	Add a Dependent Please Select Applicable Reason	☐ Marriage or Domestic Partner Addition	INDICATE DATE OF MARRIAGE OR DOMESTIC PARTNER DECLARATION		
		☐ Birth, Adoption, Guardianship, Foster Care or Qualified Medical Child Support Order (QMCSO) of Dependent Child	INDICATE DATE OF BIRTH, ADOPTION, GUARDIANSHIP, FOSTER CARE OR QUALIFIED MEDICAL CHILD SUPPORT ORDER		
☐	Name Change/Address Change		INDICATE EFFECTIVE DATE OF CHANGE		
☐	Employee Termination		INDICATE LAST DAY WORKED IN QUALIFYING EVENT DATE FIELD		
☐	Dependent Termination		INDICATE EFFECTIVE DATE OF CHANGE		
☐	COBRA/CAL-COBRA Enrollment	Please indicate Qualifying Life Event and Date in **Box 20** of Step 2			
☐	Declination of Coverage	To Decline Coverage, **fill in Step 2** and then move to Step 7 on Page 6	INDICATE GROUP EFFECTIVE DATE OR QUALIFYING LIFE EVENT DATE		
☐	Other Qualifying Life Event	Please Fill in the applicable Qualifying Life Event*			

*For a complete list of qualifying life events please use title 10 of the California code of Regulations, Section 6524

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continued on next page ➡

STEP 2 Employee Personal Information

1. Legal First name	Middle name	Legal Last name, & Suffix	2.Gender ☐ Male ☐ Female
3. Social Security Number or Tax ID Number	4. Date of birth (mm/dd/yyyy)		
5. Home address			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. **For CalCOBRA/COBRA applicants, indicate qualifying event :**

☐ Termination of employment ☐ Divorce/Legal separation ☐ Child no longer eligible ☐ Currently Enrolled in Cal-COBRA/COBRA*
☐ Reduction of hours ☐ Death of employee ☐ Medicare entitlement

*Indicate Original Date of Qualifying Event for COBRA Coverage

Date of Qualifying Event: _____

21. Marital Status: ☐ Single ☐ Married ☐ Domestic Partnership (DP)

22. Preferred spoken or written language (OPTIONAL—if not English)

23. What is the preferred method of communication? ☐ Mail ☐ Email ☐ Phone

Tell us about your race Please tell us about yourself. This information is confidential and will only be used to make sure that everyone has the same access to health care. It will not be used to decide what health insurance you qualify for.

24. Are you of Hispanic/Latino, or Spanish origin? **(OPTIONAL)** ☐ Yes ☐ No If yes, check which one(s): ☐ Other Hispanic, Latino or Spanish origin: _____
☐ Mexican, Mexican American, Chicano ☐ Salvadoran ☐ Puerto Rican ☐ Cuban ☐ Guatemalan

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

☐ White
☐ Black or African American
☐ American Indian or Alaska Native
☐ Asian Indian
☐ Cambodian
☐ Chinese
☐ Filipino
☐ Hmong
☐ Japanese
☐ Korean
☐ Laotian
☐ Vietnamese
☐ Native Hawaiian
☐ Guamanian or Chamorro
☐ Samoan
☐ Other _____

26. If you're American Indian or Alaska Native, tell us the state and the name of your federally-recognized tribe (optional):

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continued on next page ➡

STEP 3

Please tell us about yourself and your eligible enrolling dependents

California law defines a dependent for health care coverage in the following way:
"Dependent" means the spouse or registered domestic partner, or child, of an eligible employee, subject to applicable terms of the health care service plan contract covering the employee, and includes dependents of guaranteed association members if the association elects to include dependents under its health coverage at the same time it determines its membership composition.

COMPLETE THIS SECTION TO ADD COVERAGE, CANCEL COVERAGE, OR CHANGE PLANS

IMPORTANT! Plan changes are allowed during renewal and for employees who experience a qualifying event (i.e. newborn).

- **ADDITIONS (NEW ENROLLMENT/QUALIFYING EVENT):** Please see your employer for effective date guidelines based on qualifying event.
- **ADDITIONS (AT RENEWAL):** Coverage will be effective on the group's renewal date.
- **CHANGES (AT RENEWAL):** If making any plan changes, please list all covered dependents.
- **TERMINATIONS** of coverage will take effect on the LAST DAY of the month in which your request was received by Covered California for Small Business. Terminations at renewal will take effect on the group's renewal date.

This form must be received by Covered California **NO LATER THAN 30 DAYS** after the event takes place if outside renewal.

EMPLOYEE

LAST NAME (FAMILY NAME)	FIRST NAME	M.I.	SSN / TAX ID #	GENDER (M/F) ☐ Male ☐ Female

HOME ADDRESS	MAILING ADDRESS

BIRTHDATE MM / DD / YYYY	☐ HEALTH PLAN ☐ Add ☐ Cancel ☐ Change	☐ DENTAL PLAN ☐ Add ☐ Cancel ☐ Change

SPOUSE OR DOMESTIC PARTNER

LAST NAME (FAMILY NAME)	FIRST NAME	M.I.	SSN / TAX ID #	GENDER (M/F) ☐ Male ☐ Female

HOME ADDRESS	MAILING ADDRESS

BIRTHDATE MM / DD / YYYY	ARE YOU A DOMESTIC PARTNER? ☐ Yes ☐ No	IF YES, IS YOUR PARTNERSHIP REGISTERED WITH THE STATE OF CALIFORNIA? ☐ Yes ☐ No	☐ HEALTH PLAN ☐ Add ☐ Cancel ☐ Change	☐ DENTAL PLAN ☐ Add ☐ Cancel ☐ Change

CHILD**

LAST NAME (FAMILY NAME)	FIRST NAME	M.I.	SSN / TAX ID #	GENDER (M/F) ☐ Male ☐ Female

HOME ADDRESS	MAILING ADDRESS

BIRTHDATE MM / DD / YYYY	IS CHILD **BOTH** DISABLED **AND** 26 YEARS OLD OR OLDER? ☐ Yes ☐ No	☐ HEALTH PLAN ☐ Add ☐ Cancel ☐ Change	☐ DENTAL PLAN ☐ Add ☐ Cancel ☐ Change

CHILD**

LAST NAME (FAMILY NAME)	FIRST NAME	M.I.	SSN / TAX ID #	GENDER (M/F) ☐ Male ☐ Female

HOME ADDRESS	MAILING ADDRESS

BIRTHDATE MM / DD / YYYY	IS CHILD **BOTH** DISABLED **AND** 26 YEARS OLD OR OLDER? ☐ Yes ☐ No	☐ HEALTH PLAN ☐ Add ☐ Cancel ☐ Change	☐ DENTAL PLAN ☐ Add ☐ Cancel ☐ Change

CHILD**

LAST NAME (FAMILY NAME)	FIRST NAME	M.I.	SSN / TAX ID #	GENDER (M/F) ☐ Male ☐ Female

HOME ADDRESS	MAILING ADDRESS

BIRTHDATE MM / DD / YYYY	IS CHILD **BOTH** DISABLED **AND** 26 YEARS OLD OR OLDER? ☐ Yes ☐ No	☐ HEALTH PLAN ☐ Add ☐ Cancel ☐ Change	☐ DENTAL PLAN ☐ Add ☐ Cancel ☐ Change

**If you have more than 3 dependent children, please attach a separate sheet listing their required information and submit with this application.

*Can be found in your selected plans provider directory.

If your employer does not offer dependent coverage and you would like more information about how to get them covered, please go to CoveredCA.com.

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continued on next page ➡

Employee Name	Employer Name

STEP 4 Health and Dental Plan Choices

Important: Please select ONE benefit plan from Medical and/or Dental Choices by filling in the square ☐ next to the selected plan(s).

NOTE: Infertility benefits are available to employer groups when an Employer elects to provide this benefit during open enrollment or renewal periods. If an employer with 20 or more eligible employees elects to provide infertility benefits, all plans offered will include this coverage. If an employer with less than 20 eligible employees elects to provide infertility benefits, only PPO and EPO plans will include this coverage. Infertility benefits will not be included in HMO plans for groups with less than 20 eligible employees.

Health Plan	Metal Tier: Bronze	Silver	Gold	Platinum
Blue Shield of California	☐ Bronze 60 PPO 5800/60 PCP + Child Dental ☐ Bronze 60 HDHP PPO 7500/0% PCP + Child Dental Alt ☐ Trio Bronze 60 HMO 7000/70 PCP + Child Dental Alt	☐ Silver 70 PPO 2500/55 PCP + Child Dental ☐ Silver 70 HDHP PPO 2300/30% PCP + Child Dental Alt ☐ Trio Silver 70 HMO 2500/55 PCP + Child Dental ☐ Access+ Silver 70 HMO 2500/55 PCP + Child Dental	☐ Gold 80 PPO 350/25 PCP + Child Dental ☐ Trio Gold 80 HMO 250/35 PCP + Child Dental ☐ Access+ Gold 80 HMO 250/35 PCP + Child Dental	☐ Platinum 90 PPO 0/15 PCP + Child Dental ☐ Trio Platinum 90 HMO 0/20 PCP + Child Dental ☐ Access+ Platinum 90 HMO 0/20 PCP + Child Dental
Kaiser Permanente	☐ Bronze 60 HMO 5800/60 PCP + Child Dental ☐ Bronze 60 HDHP HMO 6650/0% PCP + Child Dental	☐ Silver 70 HMO 1900/65 PCP + Child Dental Alt ☐ Silver 70 HMO 2300/65 PCP + Child Dental Alt ☐ Silver 70 HMO 2900/65 PCP + Child Dental Alt ☐ Silver 70 HDHP HMO 2850/25% PCP + Child Dental ☐ Silver 70 HMO 2500/55 PCP + Child Dental	☐ Gold 80 HDHP HMO 1750/15% PCP + Child Dental Alt ☐ Gold 80 HMO 0/35 PCP + Child Dental Alt ☐ Gold 80 HMO 250/35 PCP + Child Dental ☐ Gold 80 HMO 1000/40 PCP + Child Dental Alt	☐ Platinum 90 HMO 0/10 PCP + Child Dental Alt ☐ Platinum 90 HMO 0/20 PCP + Child Dental ☐ Platinum 90 HMO 250/30 PCP + Child Dental Alt
Sharp	☐ Performance Bronze 60 HMO 5800/60 PCP + Child Dental ☐ Premier Bronze 60 HDHP HMO 6650/0% PCP + Child Dental	☐ Premier Silver 70 HMO 2500/55 PCP + Child Dental ☐ Premier Silver 70 HDHP HMO 2850/25% PCP + Child Dental ☐ Performance Silver 70 HMO 2500/55 PCP + Child Dental	☐ Performance Gold 80 HMO 350/25 PCP + Child Dental ☐ Premier Gold 80 HMO 250/35 PCP + Child Dental	☐ Performance Platinum 90 HMO 0/15 PCP + Child Dental ☐ Premier Platinum 90 HMO 0/20 PCP + Child Dental

* For health plans that do not include Child Dental, employees have the option to elect a standalone pediatric dental plan. Dependant children are eligible for Pediatric Dental coverage up to age 19.

Dental Plan	Pediatric Dental Plans	Family Dental Plans **
Delta Dental	☐ Children's Dental HMO ☐ Children's Dental PPO	☐ Family Dental HMO ☐ Family Dental PPO

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** Family dental plans offer both adult only and adult plus child coverage. Covered

Employee Name	Employer Name

STEP 5 Acknowledge: COVERED CALIFORNIA 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.

Signature of Applicant (or financially-responsible party if Applicant is under the age of 18)	Date (mm/dd/yyyy)

Print Name

STEP 6 Read and sign this application.

- I am 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 Covered California for Small Business if anything changes from what I wrote on this application. I can call my employer, my employer's Covered California Certified Insurance Agent 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 of Applicant	Date (mm/dd/yyyy)

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Employee Name	Employer Name

STEP 7 Decline Coverage: Complete this section if you are declining coverage from your employer for you or your dependents.

I am declining medical coverage for (check all that apply):

- ☐ Self
- ☐ Spouse/Domestic Partner
- ☐ Child(ren) Name(s) _____

I am declining dental coverage for (check all that apply):

- ☐ Self
- ☐ Spouse/Domestic Partner
- ☐ Child(ren) Name(s) _____

Reason for declining coverage:

- ☐ Covered by spouse's/domestic partner's group plan
- ☐ Covered by individual policy
- ☐ Covered by Tricare
- ☐ Coverage is too expensive.
  (You may want to contact Covered California at www.coveredca.com for help in understanding available options and financial assistance in the Covered California Individual Marketplace)
- ☐ Covered by Medicare
- ☐ Covered by Medi-Cal
- ☐ Covered by other: _____

I acknowledge that the coverage available to me has been explained to me by my employer and I have the right to enroll in the coverage offered. I have voluntarily decided not to enroll myself and/or my eligible dependent(s). By declining this coverage I acknowledge that I and/or my eligible dependents will have to wait until my employer's next open enrollment period to enroll or change coverage, unless eligible for a special enrollment period through a qualifying event.

Employee name	
Signature of Employee	Date (mm/dd/yyyy)

Employer _____

STEP 8 Agent Assistance: If a Certified Insurance Agent helped you complete this application, please obtain their signature below.

☐ **I did not use a Certified 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-under-stand 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 Certified Insurance Agent	Agent License #
Print Name	Date

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Employee Name	Employer Name

STEP 9

Return your completed, signed application to your employer.

Your employer will send us your application, and we will contact you if we need additional information or to let you know you have been approved for coverage.

If you are not registered to vote where you live now and would like to apply to register to vote today please visit **registertovote.ca.gov** or call 1-800-345-VOTE (8683).

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