Access Health CT Small Business

Health Coverage Application for Employers

Access Health CT Small Business (AHCT SB) offers a new way for small employers to offer health insurance to employees. AHCT SB is open to small business owners. It should take about **15 minutes** to complete this application for eligibility.

THINGS TO KNOW

Is my business eligible for AHCT SB?	Your business or organization must: • Be located or headquartered in Connecticut. • Have between 2 and 50 full-time equivalent employees, including yourself/ (FTE = 30hrs/week avg.) • Have been created at least 90 days ago.
Apply faster online	• Visit SHOP.AHCT@ct.gov • Your coverage start date may 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 or call 1-855-762-4928.
Get help	• **Contact a broker:** if you need assistance getting a broker call **1-855-762-4928** • **Online:** SHOP.AHCT@ct.gov • **Phone: 1-855-762-4928** • **En Español:** Llame a nuestro centro de ayuda gratis al **1-855-762-4928**
What happens next?	Send this completed form and your employees completed, signed applications to the address on page 4. 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 complete the enrollment process.

- We will 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 to buy health insurance through Access Health CT Small Business, Connecticut's Health Insurance Marketplace, and if eligible, to facilitate enrollment.

STEP 1 Tell us about the employer offering coverage.

Employers must be located in the same state in which they are buying health coverage and must offer coverage to all full-time employees (those working on average 30+ hours per week).

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 do you have?	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 □ Cell □ Home ( ) -	9. Other Phone Number □ Work □ Cell □ Home ( ) -
10. Fax Number ( ) -	11. Email Address

12. Notices and monthly invoices will be sent electronically. □ Check here to receive 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 □ Cell □ Home ( ) -	22. Other Phone Number □ Work □ Cell □ Home ( ) -
23. Fax Number ( ) -	24. Email Address

NEED HELP WITH YOUR APPLICATION? Contact your employer, visit SHOP.AHCT@ct.gov, or call us at 1-855-762-4928. TTY users should call 800-877-8973 and connect to 1-855-762-4928. Para obtener una copia de este formulario en Espanol, llame al 1-855-762-4928.

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STEP 3 OPTIONAL

List all employees who will 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)	Last Four Digits of Social Security Number	Email Address	Employment Status*	Date of Hire (mm/dd/yyyy)	Number of Hours Worked
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 additional pages as necessary.

STEP 4 Read and sign this application.

- I am signing this application under penalty of perjury, which means I've provided true and correct 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 AHCT SB if anything changes (and is different than) what I wrote on this application. I can call a broker, visit SHOP.AHCT@ct.gov or call **1-855-762-4928** to report changes. I have consent from everyone I will list on the application to include their personally identifiable information, like dates of birth, last four digits of their Social Security Numbers, and phone numbers.
- I know that under federal and state law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, disability or because of genetic information. I can file a complaint of discrimination by visiting www.hhs.gov/ocr/office/file or Connecticut Commission on Human Rights and Opportunities (CHRO) www.ct.gov/chro/site/default.asp

Signature	Date (mm/dd/yyyy)

STEP 5 Mail the completed application and your employee applications.

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

Access Health CT Small Business
280 Trumbull Street, 15th Floor
Hartford, CT 06103

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 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 15 minutes per application, 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, 75000 Security Boulevard, Attn: PRA Reports Clearance Office, 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 **1-855-762-4928**. Para obtener una copia de este formulario en Español, llame **1-855-762-4928**.