

Health Coverage Application for Employees

Use this application to see if you're eligible to get Access Health CT Small Business health care coverage from your employer. It should take about 15 minutes to complete this application.

THINGS TO KNOW	
Apply faster online	Visit AccessHealthCTSmallBiz.com for details about Access Health CT Small Business coverage and how to enroll.
Get help	<ul style="list-style-type: none"> • Contact your employer • Online: AccessHealthCTSmallBiz.com • Phone: 1-855-762-4928 • En Espanol: Llame a nuestro centro de ayuda gratis al 1-855-762-4928
What happens next?	<ul style="list-style-type: none"> • Return your completed signed application to your employer. • Your employer will forward your application to Access Health CT Small Business.
Alternatives	<p>If your share of the cost of employee-only coverage is more than 9.86% of your household income, you may be able to get help paying for coverage through the individual Health Insurance Marketplace.</p> <p>Visit AccessHealthCT.com to learn more.</p>
What you may need to apply	<ul style="list-style-type: none"> • Social Security Numbers (or document numbers for any legal immigrants who need insurance). • Dates of birth for all applicants.

We will keep your information private as required by law.

Who is your employer?

Employer Name & Address	
Employer Phone Number () -	Plan Selection

Get started with your application below.

[Not interested in Access Health CT Small Business health coverage?](#)

Skip to Step 4 on page 3.

STEP 1**I am interested in Access Health CT Small Business coverage from this employer**

*1. First Name, Middle Name, Last Name, & Suffix			*2. Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Widowed	
*3. Social Security Number / /		*4. Date of Birth (mm/dd/yyyy)		*5. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
*6. Home Address (leave blank if you don't have one)				
*7. City		*8. State	*9. Zip Code	10. County
11. Mailing Address (if different than above)				12. Apartment or Suite Number
13. City		14. State	15. Zip Code	16. County
*17. Email Address				
*19. Phone Number <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work () -				
20. Notices will be sent electronically. <input type="checkbox"/> Check here if you also want to get paper notices by mail.				
21. Preferred spoken language (if not English)				
22. If Hispanic/Latino, ethnicity (OPTIONAL– Check all that apply.) <input type="checkbox"/> Mexican <input type="checkbox"/> Mexican American <input type="checkbox"/> Chicano/a <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Cuban <input type="checkbox"/> Other				
23. Race (OPTIONAL – check all that apply.) <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Indian or Alaska Native <input type="checkbox"/> Filipino <input type="checkbox"/> Vietnamese <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Asian <input type="checkbox"/> Indian <input type="checkbox"/> Korean <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Samoan <input type="checkbox"/> Chinese <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Other				
24. If you're American Indian or Alaska Native, tell us the state and the name of your federally recognized tribe.				

NEED HELP WITH YOUR APPLICATION? Contact your employer, visit AccessHealthCTSmallBiz.com, 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.

*required

STEP 2**Dependent Information****Dependent #1**

1. First Name, Middle Name, Last Name, & Suffix					
2. Social Security Number / /		3. Date of Birth (mm/dd/yyyy)		4. Sex <input type="checkbox"/> Male <input type="checkbox"/> 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. Relationship to Subscriber					

Dependent #2

1. First Name, Middle Name, Last Name, & Suffix			
2. Social Security 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. Relationship to Subscriber			

STEP 3 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 I'm eligible, it will be used to help me enroll.
- I know that I must inform Access Health CT Small Business if anything changes (and is different than) what I wrote on this application. I can call my employer, visit AccessHealthCTSmallBiz.com or call 855-762-4928 to report changes.
- 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.

Authorized Signature

Date (mm/dd/yyyy)

STEP 4 If you don't want coverage from this employer.

- I decline coverage for myself
 I decline coverage for my dependent(s)

Answer these questions:

Do you have another source of health care coverage?

- Yes No

If yes, what type?

- | | | |
|--|--|--|
| <input type="checkbox"/> Individual private health insurance | <input type="checkbox"/> Medicare | <input type="checkbox"/> TRICARE |
| <input type="checkbox"/> Insurance from another job | <input type="checkbox"/> Medicaid | <input type="checkbox"/> VA health care programs |
| <input type="checkbox"/> Insurance with another person | <input type="checkbox"/> Indian Health Service | |

Employer Name	
Signature	Date (mm/dd/yyyy)

STEP 5 Return your completed, signed application to your employer.

NEED HELP WITH YOUR APPLICATION? Contact your employer, visit AccessHealthCTSmallBiz.com, 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 all 1-855-762-4928.

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.