CONNECT for HEALTH COLORADO

EN-003-01

Small Business Marketplace

Health coverage application for employers

Connect for Health Colorado provides small group plan options to Colorado employers with 2 to 50 full time equivalent employees. To be eligible to purchase small group plans, you must attest to having 50 or fewer full-time equivalent employees and that you are offering coverage to all of these employees. You must have either your company offices or a primary work site in Colorado to purchase with Connect for Health Colorado.

THINGS TO KNOW

Who can use this application?	• Employers who cannot apply online.
Is my business eligible for the Marketplace?	Your business or organization must: • Have a primary business address and employees within Colorado, • Have at least one common-law employee, • Have 50 or fewer full-time equivalent (FTE) employees, and • Offer coverage through the Marketplace to all full-time employees
Apply faster online	• Visit ConnectforHealthCO.com to apply online. • 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. • Eligible employers who submit their completed application online, whose employees complete their enrollment, and who submit their initial payment by the 25th of the month will generally be issued coverage by the 1st of the next month.
Get help	• Online: ConnectforHealthCO.com • Phone: Call our Service Center at 1-855-PLANS-4-YOU (1-855-752-6749) • Contact an agent/broker or Assistance Site: Visit ConnectforHealthCO.com or call 1-855-PLANS-4-YOU (1-855-752-6749) • If you need help in a language other than English, call and tell the service representative the language you need • **En Español**: Llame a nuestro centro de ayuda gratis al 1-855-PLANS-4-YOU (1-855-752-6749) • Pages 7-8 have a glossary; terms marked with an (i) in the application can be found in the glossary • If someone is helping you fill out this application, you may need to complete **Worksheet A**.
What happens next?	You'll send this form and your employees' completed, signed applications and employee addendums to the address on page 6. Please allow 10 business days before inquiring on your application. **Do not drop existing coverage** until your coverage effective date is confirmed by Connect for Health Colorado.

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 Small Business Health Insurance and, if eligible, to facilitate enrollment.

NEED HELP WITH YOUR APPLICATION? Contact an agent/broker or Assistance Site with questions, visit ConnectforHealthCO.com, or call us at 1-855-PLANS-4-YOU (1-855-752-6749). TTY users should call 1-855-346-3432. Para obtener una copia de este formulario en Español llame 1-855-PLANS-4-YOU (1-855-752-6749).

Additional Language Assistance

English	If you need help understanding this document, please call 1-855-752-6749. We can provide an interpreter for free.
Español	Si necesita ayuda para entender mejor este documento comuníquese al 1-855-752-6749. Le podemos asistir gratuitamente con un intérprete.
普通话	如果您在理解本文方面需要帮助，请致电 1-855-752-6749。我们将免费提供口译服务。
Tiếng Việt	Nếubạncầntrợgiúptìmhiểutàiliệunày, vuilònggọi 1-855-752-6749. Chúngtôicóthểcungcấpphiên dịchviênmiễnphí.
한국어	이문서를이해하는데있어도움이필요할경우 1-855-752-6749번으로전화하십시오. 무료통역서비스를제공해드립니다.
Русский	Если вам нужна помощь, чтобы понять этот документ, пожалуйста, позвоните по номеру 1 855 752 6749. Мы можем предоставить бесплатные услуги переводчика.
العربية	إذا كنت بحاجة إلى مساعدة في فهم هذا المستند، فالرجاء الاتصال على 1-855-752-6749. يمكنك توفير مترجم مجاناً.
Ntawv Hmoob	Yogkojxav tau kevpabqhiakomnkagsiabcovntaubntawvno, thovhurau 1-855-752-6749. Pebtuajyeempabib tug kwstxhaislus pub dawbraukoj.
አማርኛ	ይህን ሰነድ ለመረዳት እገዛ ከፈለጉ እባክዎ በስ.ቁ. 1-855-752-6749 ይደውሉ። አስተርጓሚ በነፃ ልናቀርብልዎት እንችላለን።
नेपाली	यदि तपाईलाई यो कागजात बुझ्न सहयोगको चहनि्छ भने, कृपया 1-855-752-6749 मा टेलफिोन सम्पर्क गर्नुहोस् । हामी तपाईलाई नि:शुल्क दोभाषे उपलब्ध गराउन सक्छौं ।
Soomaali	Haddii aad u baahantahay kaalmo si aad u fahanto xogtan, fadlan la soo hadal 1-855-752-6749. Waxa aannu kuu heli karaynaa afceliyeen (turjubaan) bilaa lacag ah.
Français	Veuillez téléphoner au 1-855-752-6749 si vous avez besoin d'aide concernant l'explication de ce document. Nous pouvons vous proposer un interprète gratuitement.
Deutsch	Wenn Sie zum besseren Verständis dieses Dokuments Hilfe benötigen, rufen Sie uns unter 1-855-752-6749 an. Wir können Ihnen kostenlos einen Dolmetscher zur Verfügung stellen.

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Para obtener una copia de este formulario en Español llame 1-855-PLANS-4-YOU (1-855-752-6749).

STEP 1 Tell us about the employer offering coverage

1. Employer Legal Business Name	2. Federal Employer Identification Number (EIN)(i)

3. Doing business as(i)

4. Employer Type
□ Private sector □ Church/church-affiliated
□ State/local government □ Non-profit organization □ Foreign government

5. Private Sector Type (if applicable)
□ C Corporation □ S Corporation □ 1040 Schedule C Business (self-employed) □ Partnership
□ Tax-exempt organization (including corporation, trust, limited liability company, or association)

6. Legal Address of Business(i)			7. Year Established (yyyy)	
8. City	9. State	10. ZIP code	11. County	12. Country

13. Phone Number	14. Other Phone Number

15. Fax Number

17. How many full-time equivalent employees(i)?

18. Was your business previously self-insured during the last 12 months? □ Yes □ No	19. Plan Year(i):_____

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STEP 1 Tell us about the employer offering coverage-continued

20. Billing Address of Business(i) (if different than legal address)

21. City	22. State	23. ZIP code	24. County	25. Country
26. Phone Number		27. Other Phone Number		
28. Fax Number				

29. Colorado Worksite Address of Eligible Employees(i) (if different than legal address)

30. City	31. State	32. ZIP code	33. County
34. Phone Number		35. Other Phone Number	
36. Fax Number			

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STEP 2 Tell us who to contact about this application

Primary Contact: This individual will be the person associated with this business account. Notices and invoices will be sent to this individual.

1. First name, Middle name, Last name, & Suffix	2. Date of Birth (mm/dd/yyyy)

3. Title

4. Mailing Address (if different from legal business address)

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

9. Phone Number ☐ Work ☐ Home ☐ Cell ( ) – Ext.	10. Other Phone Number (optional) ☐ Work ☐ Home ☐ Cell ( ) – Ext.
11. Fax Number (optional) ( ) –	12. Email Address
13. Preferred Method of Contact ☐ Email ☐ Mail	14. Preferred Spoken & Written Language ☐ English ☐ Spanish

Secondary Contact (optional)

15. First name, Middle name, Last name, & Suffix	16. Date of Birth (mm/dd/yyyy)

17. Title

18. Mailing Address (if different from legal business address)

19. City	20. State	21. ZIP code	22. County

23. Phone Number ☐ Work ☐ Home ☐ Cell ( ) – Ext.	24. Other Phone Number (optional) ☐ Work ☐ Home ☐ Cell ( ) – Ext.
25. Fax Number (optional) ( ) –	26. Email Address
27. Preferred Method of Contact ☐ Email ☐ Mail	28. Preferred Spoken & Written Language ☐ English ☐ Spanish

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STEP 3 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)	Employment Type* Employment Status**	Eligible/Ineligible	Annual Salary	Employee Code(i)
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, temporary, or seasonal.
** Active or Inactive
Attach more sheets as necessary.

STEP 4 Eligibility

☐ I attest that my business employs 50 or fewer full-time equivalent employees, and my business is eligible for small group coverage in the state of Colorado.

☐ I attest that I am offering health coverage through the Marketplace to all full-time employees.

STEP 5 Plan Selection

Enrollment Period(i)

Effective Date of Health Plan:_____	Start Date of Enrollment Period:_____	End Date of Enrollment Period:_____

Health Insurance Plans

☐ Employees can select one plan from one carrier	Carrier: Plan:
☐ Employees can select any plan from one carrier	Carrier:
☐ Employees can select any plan from one coverage level(i) from any carrier	Coverage levels: ☐ Bronze ☐ Silver ☐ Gold ☐ Platinum
☐ Employees can select any plan from two adjacent coverage levels from any carrier	Coverage levels (select two): ☐ Bronze ☐ Silver ☐ Gold ☐ Platinum

Defined Contribution(i)

Coverage for Health Insurance

Coverage for	Employer Contribution	
Employee	_____% OR up to $_____	Monthly (whichever is lower)
☐ Spouse	_____% OR up to $_____	Monthly (whichever is lower)
☐ Dependents	_____% OR up to $_____	Monthly (whichever is lower)

Coverage for Dental Insurance

Coverage for	Employer Contribution	
Employee	_____% OR up to $_____	Monthly (whichever is lower)
☐ Spouse	_____% OR up to $_____	Monthly (whichever is lower)
☐ Dependents	_____% OR up to $_____	Monthly (whichever is lower)

Carrier:	Plan(s):

STEP 6 Read & Sign This Application

1. I am authorized to attest to the eligibility of this employer to offer small group coverage to his/her employees. To the best of my ability, I have provided true and correct answers to all the questions on this application for use by Connect for Health Colorado to offer small group coverage to the employees. I know that if I am not truthful there may be a penalty. I understand that I may be asked to provide verification such as an Unemployment Insurance Tax Report (UITR) or other documentation to support my application.

2. I know that my information on this form will 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.

3. I know that I must tell Connect for Health Colorado if anything changes from (and is different than) what I originally wrote on this application. I can visit ConnectforHealthCO.com or call 1-855-PLANS-4-YOU (1-855-752-6749) to report changes.

4. I have consent from everyone listed on the application to include their personally identifiable information, such as dates of birth, Social Security numbers, addresses, and phone numbers.

5. I know that under federal law, discrimination is not 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.

My right to appeal:

If I think Connect for Health Colorado has made a mistake, I can appeal its decision. To appeal means to tell someone at Connect for Health Colorado that I think the action is wrong and ask for a fair review of the action. I know that I can find out how to appeal by contacting the Marketplace at 1-855-PLANS-4-YOU or by visiting the website at ConnectforHealthCO.com My eligibility and other important information will be explained to me.

☐ **By checking this box**, I agree that I have read and agreed to the Read & Sign This Application language for the employer for use of Connect for Health Colorado to offer small group coverage to employees of the business.

Print Full Name (Primary Contact)

Signature	Date (mm/dd/yyyy)

Print Full Name (Secondary Contact)

Signature	Date (mm/dd/yyyy)

STEP 7 Mail the completed application & your employee applications

Mail your completed application, including all employee applications to:

Connect For Health Colorado
Small Business Applications
P.O. Box 35033
Colorado Springs, CO 80935

If you want to **register to vote**, you can complete a voter registration form at: govoteColorado.com/C4HCO

Glossary(i)

Term	Definition
Billing Address of Business	The address of a business or organization where bills and invoices can be sent for processing.
Colorado Worksite Address of Eligible Employees	The address of the primary Colorado work site. Employers do not need to be headquartered in Colorado to use Connect for Health Colorado services, but they do need to provide a primary Colorado work site address.
Coverage Level	Beginning in 2014, health insurers must offer health plans in groups according to how much of the total costs of health care services will be paid for by the carrier and by the customer, also known as metal tiers: bronze, silver, gold and platinum. Each coverage level shows the expected portion of total health care costs a health insurance carrier will pay. This is called the actuarial value of the health plan. For example, a health plan with an actuarial value of 80 percent would be expected to pay an average of 80 percent of medical expenses, and the customer would pay the remaining 20 percent, on average, through deductible, co-pays, etc. Coverage levels are not a measure of quality. A bronze plan is required to have an actuarial value of about 60 percent, which means the health insurance carrier will pay for about 60 percent of health care costs and the customer will pay 40 percent. A silver plan is required to have an actuarial value of about 70 percent, which means the health insurance carrier will pay for about 70 percent of health care costs and the customer will pay 30 percent. A gold plan is required to have an actuarial value of about 80 percent, which means the health insurance carrier will pay for about 80 percent of health care costs and the customer will pay 20 percent. A platinum plan is required to have an actuarial value of about 90 percent, which means the health insurance carrier will pay for about 90 percent of health care costs and the customer will pay 10 percent.
Defined Contribution	Employers can set limits on the amount of the monthly premium they will pay for their employees. You can set limits by either defining a percent of the premium you will pay or by setting a dollar limit or you can define a percent with a maximum dollar amount. Employers who offer small group coverage are required to contribute *at least* the lesser of either $125/month or 50% of the employee-only (no spouse or dependents) monthly premium. In other words, if the employee-only monthly premium is $250/month or more, the employer must pay *at least* $125/month of the premium in order to offer small group coverage to their employees. If the employee-only monthly premium is less than $250/month, the employer must pay *at least* half of the monthly premium in order to offer small group coverage to their employees.
Doing business As	Doing business as refers to a name that a business or organization uses when operating in the public. This may be different than theorganization's legal name.
Employee Code	The employee code is a unique number or code you provide to your employee to identify them in the Connect for Health Colorado System. This may be your internal employee ID.
Enrollment Period	During this time, employees can view and enroll in health insurance plans selected by you. If employees do not participate during this enrollment period, they may not be eligible for coverage under your plan. Please leave enough time between the end of the enrollment period and the date you want coverage to start for Connect for Health Colorado and the selected insurance carrier(s) to process your application and enroll your employees. Coverage for most plans begins on the first day on the month.

Federal Employee Identification Number	The Federal Employer Identification Number (EIN) is also known as a federal tax identification number and is used to identify a business entity.
Full Time Employees	The combined sum of Full-Time Employees (those who work 30 hours or more per week) and Part-Time Employees converted to their full-time equivalent under the Patient Protection and Affordable Care Act rules. See IRS Code § 4980H(c)(2) for specific rules on counting employees.
Legal Address of Business	The street address of a business or entity's registered office.
Plan Year	A 12-month period of benefits coverage under a group health plan. This 12-month period may not be the same as the calendar year.