Small Business Health Options Program (SHOP) Application for Employers

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AFFORDABLE HEALTH COVERAGE FOR MAINE

Use this form to request an eligibility determination that can be used to apply for the Small Business Health Options Program (SHOP) and the Small Business Health Care Tax Credit. Enrolling in a Small Business Health Options Program (SHOP) plan is generally the only way for a small business to claim the Small Business Health Care Tax Credit. Once we have received your application, we will determine if you qualify for a subsidy.

THINGS TO KNOW

Is my business eligible for SHOP and the Small Business Health Care Tax Credit?

To be eligible, your business or organization must:

- Have a primary business address within Maine
- Have at least one common-law employee
- Have 50 or fewer full-time equivalent (FTE) employees
- Offer coverage through SHOP to all full-time employees

Get Help

- Online: Contact an agent or broker, or find an agent or broker near you at **CoverME.gov.**
- Phone: Call the **CoverME.gov** Consumer Assistance Center at **1-866-636-0355**. TTY/TDD users should call 711.

What Happens Next?

This form should be sent to the address on page 4. You can begin working with the insurance carrier or broker of your choice at any time. Carriers and brokers can provide you with information you need to compare cost and coverage options, to select a plan, and to complete the enrollment process. Carriers will provide CoverME.gov with the final participation rate for your company, which must meet or exceed 70%. You may also contact an insurance agent or broker, or an insurance company offering SHOP plans, to begin the application and enrollment process.

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 the Small Business Tax Credit.

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Step 1 Information about the Business Offering Coverage

Employers must be located within the same state they're 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 (if applicable)

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. To be eligible to participate in the Small Business Health Options Program (SHOP), your business must:

- Have a primary business address within the state where you're purchasing coverage;
- 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 me and to my company.***

Step 2 Contact Information for the 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. Notices and monthly invoices may be sent electronically.
☐ Check here if this person also wants to get paper notices by mail.

12. Preferred language (if not English)

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Step 3 For Agents and Brokers ONLY:

Complete this section if you're an agent or broker filling out this application for an Employer.

1. First name	Middle name	Last name	Suffix
2. Organization name (if applicable)		3. Maine State License Number	
4. Phone number ☐ Work ☐ Home ☐ Cell		5. Second phone number ☐ Work ☐ Home ☐ Cell	
6. Fax number	7. Email address	Re-enter email address	

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Step 4 Read & Sign This Application

- I know that my information on this form will only be used to determine eligibility for the tax credit and 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 **CoverME.gov** if anything changes (or is different than) what I wrote on this application. I can visit **CoverME.gov** or call **1-866-636-0355** to report any changes.
- I know that under state and 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.**
- I have consent from everyone I will list on the application to include their personally identifiable information, like dates of birth, Social Security numbers, addresses, and phone numbers.
- I am signing this application under penalty of perjury, which means I have provided true answers to all the questions on this form to the best of my knowledge. I know that I may be subject to penalties under federal law if I provide false and/or untrue information.

Name of person signing*

Signature*	Date (mm/dd/yyyy)*

Step 5 Mail Completed Application

Mail your signed application to:

CoverME.gov Consumer Assistance Center

P.O. Box 616

Augusta, ME 04332-6626

We will let you know if you are eligible to buy SHOP coverage for your small business and provide you with the information you can use to claim the Small Business Health Care Tax Credit.

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, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Permission for information submitted

By submitting this application, you represent that you have permission from all of the people whose information is on the application to both submit their information to the Marketplace and receive any communications about their eligibility and enrollment.

Privacy Act Statement (effective 11/01/2021)

We are authorized to collect the information on this form and any supporting documentation, including social security numbers, 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), and the Social Security Act.

We need the information provided about you and the other individuals listed on this form to determine eligibility for: (1) enrollment in a qualified health plan through CoverME.gov, (2) insurance affordability programs (such as Medicaid, advanced payment of the premium tax credits, and cost sharing reductions), and (3) certifications of exemption from the individual responsibility requirement. As part of that process, we will verify the information provided on the form, communicate with you or your authorized representative, and eventually provide the information to the health plan you select so that they can enroll any eligible individuals in a qualified health plan or insurance affordability program. We will also use the information provided as part of the ongoing operation of CoverME.gov, including activities such as verifying continued eligibility for all programs, processing appeals, reporting on and managing the insurance affordability programs for eligible individuals, 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 CoverME.gov, advanced payment of the premium tax credits, cost sharing reductions, or an exemption from the shared responsibility payment. If you don't have an exemption from the shared responsibility payment and you don't maintain qualifying health coverage for three months or longer during the year, you 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 applications, determine eligibility, and operate, we will need to share selected information that we receive outside of CoverME.gov, including to:

1. Federal agencies, (such as the Internal Revenue Service, Social Security Administration and Department of Homeland Security), or local government agencies. We may use the information you provide in computer matching programs with any of these groups to make eligibility determinations, to verify continued eligibility for enrollment in a qualified health plan or Federal benefit programs, or to process appeals of eligibility determinations;
2. Other verification sources including consumer reporting agencies;
3. Employers identified on applications for eligibility determinations;
4. Applicants/enrollees, and authorized representatives of applicants/enrollees;
5. Agents, Brokers, and issuers of Qualified Health Plans, as applicable, who are certified by CoverME.gov who assist applicants/enrollees;
6. Contractors engaged to perform a function for CoverME.gov; and
7. Anyone else as required by law.

This statement provides the notice required by the Privacy Act of 1974 (5 U.S.C. § 552a(e)(4)).