access health CT
small business

Employer Group Application

This checklist will help you to ensure that all information needed to process your application is included with this application.

Employer Checklist

- [ ] **Employer Data**
- [ ] **Primary Contact Data**
- [ ] **Employer Data/Primary Contact Info Signature**
- [ ] **Group Plan Selection Information**
- [ ] **Broker Information (if applicable)**
- [ ] **Employer Electronic Funds Transfer Information**

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.

Must answer all four questions as "Yes" to qualify.

Does your business have a tax ID in the State of Connecticut or can you provide proof of application for a Connecticut Tax ID? ☐ Yes ☐ No

Does your business have at least one W-2 employee who is not an immediate family member and will be accepting coverage when offered? ☐ Yes ☐ No

Does your business have 50 or fewer Full Time Equivalent employees? ☐ Yes ☐ No

Will you be offering coverage to all full-time employees (those working 30+ hours per week)? ☐ Yes ☐ No

STEP 1 Tell us about the employer offering this 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.

Full Legal Name:			
Doing Business As:			
CT Employer Tax Identification:		Employer Type: ☐ For Profit ☐ Not For Profit	
Primary Business Address:			
City:	State:	Zip Code:	County:
How Many Full-Time Equivalent Employees?		SIC Code:	

STEP 2 Tell us who to contact about this application.

Primary Contact Information

First Name, Middle Name, Last Name, & Suffix:		
Title:	Primary Phone Number:	Fax Number:
Email Address:		

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 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 AccessHealthCTSmallBiz.com 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

Authorized Signature _____ Date (mm/dd/yyyy) _____