access health CT small business

Health Coverage Application for Employees

Use this application to see if you're eligible to get Access Health CT Small Business (AHCT SB) 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 AHCT SB coverage and how to enroll in Connecticut's Health Insurance Marketplace.
Get help	• 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?	• Return your completed signed application to your employer. • Your employer will forward your application to AHCT SB.
Alternatives	If your share of the cost of employee-only coverage is more than 9.5% of your household income, you may be able to get help paying for coverage through the individual Health Insurance Marketplace. Visit AccessHealthCTSmallBiz.com to learn more.
What you may need to apply	• 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 ( ) –	Date of Hire:	Plan Selection:

Get started with your application below.

Not interested in AHCT SB health coverage?

Skip to Step 4 on page 4.

STEP 1 I am interested in AHCT SB coverage from this employer.

*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. Mailing Address (if different that above)			12. Apartment or Suite Number
13. City	14. State	15. Zip Code	16. County

*17. Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	*18. Email Address
*19. Phone Number ☐ Cell ☐ Home ☐ Work ( ) –	20. Other Phone Number ☐ Cell ☐ Home ☐ Work ( ) –

21. Notices will be sent electronically. ☐ Check here if you also want to get paper notices by mail.

22. Preferred spoken language (if not English)

23. If Hispanic/Latino, ethnicity (OPTIONAL– Check all that apply.)
☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other

24. Race (OPTIONAL – check all that apply.)
☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Filipino ☐ Vietnamese ☐ Guamanian or Chamorrow
☐ Asian Indian ☐ Korean ☐ Native Hawaiian ☐ Samoan ☐ Chinese ☐ Other Pacific Islander ☐ Other

25. If you're American Indian or Alaska Native, tell us the state and the name of your federal-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 all 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 ☐ 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			

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			

Dependent #3

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			

Dependent #4

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			

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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 onthis 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?

☐ Individual private health insurance
☐ Insurance from another job
☐ Insurance with another person
☐ Medicare
☐ Medicaid
☐ Indian Health Service
☐ TRICARE
☐ VA health care programs

Employee Name	
Signature	Date (mm/dd/yyyy)

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

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.

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