

Small Business

Health coverage application for EMPLOYEES

Use this application to see if you are eligible for Vermont Health Connect Small Business health coverage from your employer. You will need to use information provided by your employer to proceed with this application. It should take about **10 minutes** to complete.



Apply faster and easier online by visiting HealthConnect.Vermont.gov

The website offers information about Vermont Health Connect and can help you choose a health plan that meets your needs, from among the options your employer has selected.



Get help with this application

Ask your employer who to call with questions.

- **Online:** HealthConnect.Vermont.gov
- **Phone:** Call our Support Center toll-free at **1-855-499-9800**.
- **Find a navigator or contact your employer's broker:** Call **1-855-554-4488** or visit the website at HealthConnect.Vermont.gov.
- **TTY:** If you are hearing impaired, call **1-888-834-7898**.



What happens next?

- If someone is helping you fill out this application, you may need to complete **Appendix A**.
- You must **return your completed and signed application to your employer**. Your employer will send us your completed and signed application.
- We will contact you with information about how to start a Vermont Health Connect account, find out about costs, coverage, plan options, and how to enroll in a plan.



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 Vermont Health Connect. Visit HealthConnect.Vermont.gov or call **1-855-499-9800** to learn more.



If you need interpretation services...

إذا أنت ترغب خدمات الترجمة الفورية اتصل برقم 1-855-499-9800 (Arabic)
 Ako su Vam potrebne usluge tumačenja, pozovite 1-855-499-9800. (Bosnian)
 စကားပြန် ဝန်ဆောင်မှုလုပ်ငန်းကိုအလိုရှိပါက 1-855-499-9800 သို့ဖုန်းဆက်ခေါ်ပါ။ (Burmese)
 Si vous avez besoin de services d'interprétation, appelez le 1-855-499-9800. (French)
 Mugihe woba ushaka impfashanyo yo gusigurirwa, hamagara uyu murungo 1-855-499-9800. (Kirundi)
 यदि तपाईंलाई दोभाषे सेवाको जरुरत परेमा, 1-855-499-9800 मा कल गनुर्होस्। (Nepali)
 Haddii aad u baahan tahay adeegyo turjumaan, wac 1-855-499-9800. (Somali)
 Si usted necesita servicios de interpretación, llame al 1-855-499-9800. (Spanish)
 Ikiwa unahitaji huduma za ukalimani, piga simu 1-855-499-9800. (Swahili)
 Nếu quý vị cần dịch vụ thông ngôn, hãy gọi 1-855-499-9800. (Vietnamese)

Your information is private.

- We will keep your information private as required by law.
- Your answers on this form will only be used to see if you qualify for health coverage through the Small Business program with Vermont Health Connect and to help you enroll.

You may keep this page for future reference. Your Rights and Responsibilities are on the back of this page. Be sure to read through them. If you need help understanding something, contact Vermont Health Connect at 1-855-499-9800.

Your Rights and Responsibilities

We need the information we asked for to decide if you qualify for health coverage if you choose to apply. We may check your answers using information from the Internal Revenue Service (IRS), Social Security, the Department of Homeland Security, and/or a consumer reporting agency. If the information does not match, we may ask you to send us proof.

Quality Control. Vermont Health Connect may select your application for a quality control review. By signing your application, you agree to give proof of required information. If you are not able to give the proof needed, you are authorizing Vermont Health Connect to get it.

Confidentiality. Your confidential information is protected as required by federal and state laws and regulations. The use and disclosure of information concerning applicants, enrollees, and legally-liable third parties is restricted to purposes directly connected with the administration of programs, or as otherwise required by law.

Information Sharing. By signing your application you give Vermont Health Connect permission to share information about you to assist you with program enrollment. Your permission covers the following kinds of information:

- Information or proofs needed to complete your application.
- The status of your application including the program(s) you are enrolled in and the effective date of enrollment.
- The reason you are not eligible for a benefit, if your application is denied or your benefits end.
- The effective date(s) of your renewal(s) for benefits and any outstanding information or verifications needed to assist your renewal.
- Employers will not have access to employee information other than what is needed for the application and enrollment process.
- Individuals who assist in the application process, such as a navigator or broker, will not have access to employee information other than what is needed for the application and enrollment process.

Timely Eligibility Determination. Vermont Health Connect must make a decision on your application no later than 30 days after your application date unless delay is caused by an unexpected emergency or administrative problem beyond the Department's control, or yours. **If you do not get a decision within 30 days**, you may call Vermont Health Connect at **1-855-499-9800** for more information or to request a fair hearing.

Your Right to Appeal. If you think Vermont Health Connect has made a mistake, you can appeal its decision. To appeal means to tell someone at Vermont Health Connect that you think the action is wrong, and ask for a fair review of the action. Contact Vermont Health Connect's Small Business Hotline at **1-855-499-9800**, or Health Care Advocate at Vermont Legal Aid at **1-800-917-7787** to find out how to appeal. You can be represented in the process by someone other than yourself. Eligibility and other important information will be explained to you when you call Vermont Health Connect.

Complaints, Grievances, Appeals & Fair Hearings. The Agency of Human Services offers several ways to address dissatisfaction with our programs and resulting eligibility decisions. A **"complaint"** is about a general process or program or personnel; there is no formal response back to the individual. A **"grievance"** is usually about an issue or incident within the last 60 days that is not about covered services, authorized services or eligibility. A response is usually provided within 90 days. An **"appeal"** is usually a request to review a recent decision that denied, terminated, or reduced services. An appeal can also be expedited if the individual feels waiting would cause them harm, and a fair hearing can also be requested at the same time. A **"fair hearing"** is a legal process where the Vermont Human Services Board reviews a recent decision that denied, terminated, or reduced services. A fair hearing is scheduled within 30 days of the request but there is no time limit on when a decision will be made. You may attend the review by phone or in person and bring someone who can help you explain why the decision was unfair. It is also possible to appeal a fair hearing decision with the Vermont Supreme Court. Contact Vermont Health Connect at **1-855-499-9800** or write to the Human Services Board, 120 State Street, Montpelier, VT 05620-4301 (3 V.S.A. §3091).

Please be aware there is no right to a fair hearing when either state or federal law requires automatic case adjustments for classes of enrollees, unless the reason for an individual fair hearing is incorrect eligibility determination. These case adjustments are called **"mass changes."**



Who is your employer?

Business name	Business phone number () -
Business mailing address	
What is your primary work site address?	

Not interested in Vermont Health Connect health coverage?

If you do not want Vermont Health Connect health coverage from your employer, skip to Step 3 on page 2.

STEP 1

I am interested in Vermont Health Connect Small Business health coverage from this employer.

Information we need about you, the employee. Please print clearly.

1. First name, middle name, last name & suffix (Jr., Sr., III, etc.)			
2. List any other names you have been known by, including a maiden name or alias.			
3. Social Security number/Tax ID 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 do not have one)			7. Apartment or suite number
8. City	9. State	10. ZIP code	11. County
12. Mailing address line 1 (if different from home address)			13. Apartment or suite number
14. Mailing address line 2 (If applicable, include an "in-care-of" person here. For an Authorized Representative, complete Appendix A.)			
15. City	16. State	17. ZIP code	18. County
19. Email address			
20. Phone number <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work () -		21. Other phone number <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work () -	
22. Notices will be sent electronically. You must go to HealthConnect.Vermont.gov and create an online account to receive electronic notices. <input type="checkbox"/> Check here if you also want to get paper notices by mail.			
23. Preferred spoken or written language (if not English)			
24. 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			
25. Race (OPTIONAL—Check all that apply.)			
<input type="checkbox"/> White	<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Filipino	<input type="checkbox"/> Vietnamese
<input type="checkbox"/> Black or African American	<input type="checkbox"/> Asian Indian	<input type="checkbox"/> Japanese	<input type="checkbox"/> Other Asian
<input type="checkbox"/> Chinese	<input type="checkbox"/> Korean	<input type="checkbox"/> Native Hawaiian	<input type="checkbox"/> Guamanian or Chamorro
			<input type="checkbox"/> Samoan
			<input type="checkbox"/> Other Pacific Islander
			<input type="checkbox"/> Other _____
26. If you are American Indian or Alaska Native, tell us the state and the name of your federally-recognized tribe			

STEP 2

If you DO want Vermont Health Connect coverage from this employer, read and sign here.

- 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 am eligible, it will be used to help me enroll.
- I know that I must tell Vermont Health Connect if anything changes (or is different than) what I wrote on this application. I can visit [HealthConnect.Vermont.gov](https://www.healthconnect.vermont.gov) or call **1-855-499-9800** 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.
- If I think Vermont Health Connect has made a mistake, I can appeal its decision. To appeal means to tell someone at Vermont Health Connect that I think the action is wrong, and ask for a fair review of the action. I understand that I can find out how to appeal by contacting Vermont Health Connect's Small Business Hotline at **1-855-499-9800**, or Health Care Advocate at Vermont Legal Aid at **1-800-917-7787**. My eligibility and other important information will be explained to me when I call Vermont Health Connect. I know that I can be represented in the process by someone other than myself.
- I have read and understand my rights and responsibilities as they are described on page ii of this application.
- 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.

**You MUST sign below if you want health coverage from this employer.
Unsigned applications will not be processed and will be returned for a signature.**

Not signing the application may delay health coverage. If you are an **Authorized Representative** you may sign below, as long as you have provided the information required in **Appendix A**.

Print employee name

Signature

Date (mm/dd/yyyy)

STEP 3

If you DO NOT want Vermont Health Connect coverage from this employer, answer the following and sign below.

- I do not want health coverage from this employer.** If this employer offers health coverage for my dependents, I decline that offer of coverage, too.

Answer these questions:

Do you have another source of health coverage? Yes No

If yes, what type?

Individual private health insurance

Medicare

TRICARE

Insurance from another job

Medicaid

VA health care programs

Insurance through another person's job

Indian Health Service

- If this employer offers dental coverage, I do not want that coverage.** If this employer offers dental for my dependents, I decline that offer of coverage, too.

**Sign below only if you DO NOT want health coverage from this employer.
Unsigned applications will not be processed and will be returned for a signature.**

If you are an **Authorized Representative** you may sign below, as long as you have provided the information required in **Appendix A**.

Print employee name

Signature

Date (mm/dd/yyyy)

STEP 4

Return your completed and signed application to your employer.

Your employer will send us your application, and you will hear back from us with details about how to start a Vermont Health Connect employee account, find out about costs and coverage, and enroll in a plan.

Voter Registration. If you are not registered to vote where you live now, would you like a voter registration application? Yes No

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 0938-1194. The time required to complete this information collection is estimated to average 10 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.

 **NEED HELP WITH YOUR APPLICATION?** Contact a navigator or your employer's broker with questions at **1-855-554-4488**, call the Small Business Hotline at **1-855-499-9800**, or visit **HealthConnect.Vermont.gov**. TTY users call **1-888-834-7898**.

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APPENDIX A

Assistance Completing the Application

APPLICANT Information

Applicant first name, middle name, last name & suffix (Jr., Sr., III, etc.)	Applicant Social Security number _ _ _ - _ _ - _ _ _
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You can choose an AUTHORIZED REPRESENTATIVE.

You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an Authorized Representative. If you are a legally appointed representative for someone on the application (power of attorney, legal guardian) submit proof with this form.

1. Name of Authorized Representative (first name, middle name, last name & suffix (Jr., Sr., III, etc.))		
2. Address		3. Apartment or suite number
4. City	5. State	6. ZIP code
7. Phone number () -		
8. Organization name		9. ID number (if applicable)
By signing, you allow this person to sign your application, get official information about the application, and act for you on all future matters with this agency.		
10. Your signature		11. Date (mm/dd/yyyy)

You can choose an ALTERNATE REPORTER.

You can give a trusted person permission to only get copies of notices about your application and about coverages for yourself and others on the application. This person is called an Alternate Reporter. An Alternate Reporter cannot act for you or report changes for you, but they can help you understand the notices or remind you if we ask you for information. An Alternate Reporter can also be an Authorized Representative.

1. Name of Alternate Reporter (first name, middle name, last name & suffix (Jr., Sr., III, etc.))		
2. Address		3. Apartment or suite number
4. City	5. State	6. ZIP code
7. Phone number () -		
8. Organization name		9. ID number (if applicable)
By signing, you allow this person to only receive copies of notices about your coverage and the coverage for others on the application and all future matters with this agency.		
10. Your signature		11. Date (mm/dd/yyyy)

If you want to change your Authorized Representative or Alternate Reporter, contact Vermont Health Connect at 1-855-899-9600.

For certified application counselors, navigators, and brokers only.

Complete this section if you are a certified application counselor, navigator, or broker filling out this application for somebody else.

1. Application start date (mm/dd/yyyy)	
2. First name, middle name, last name & suffix (Jr., Sr., III, etc.)	
3. Organization name	4. ID number (if applicable)

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