




STEP 1 Tell us about the employer offering coverage.

Please print clearly.

 **NOTE:** Use this form to request an eligibility determination that can be used to apply for the Small Business tax credits.

1. Employer name		2. Federal Employer Identification Number (EIN)	
3. Doing business under a different name			
4. Employer type <input type="checkbox"/> Private sector (profit & non-profit) <input type="checkbox"/> Church/church affiliated <input type="checkbox"/> State/local government <input type="checkbox"/> Foreign government <input type="checkbox"/> Tribal government and tribally-owned or sponsored organizations and businesses			
5. Primary business address			
6. City	7. State	8. ZIP code	9. County
10. How many full-time employees?		11. <input type="checkbox"/> Yes, I am offering health coverage to all full-time employees.	

STEP 2 Tell us who to contact about this application.

Primary contact

1. First name, middle name, last name & suffix (Jr., Sr., III, etc.)			
2. Title			
3. Mailing address (if different from primary business address above)			
4. City	5. State	6. ZIP code	7. County
8. Phone number <input type="checkbox"/> Work <input type="checkbox"/> Home <input type="checkbox"/> Cell () -		9. Other phone number <input type="checkbox"/> Work <input type="checkbox"/> Home <input type="checkbox"/> Cell () -	
10. Fax number () -	11. Email address		
12. Preferred spoken or written language (if not English)			

Secondary contact (optional)

14. First name, middle name, last name & suffix (Jr., Sr., III, etc.)			
15. Title			
16. Mailing address (if different from primary business address above)			
17. City	18. State	19. ZIP code	20. County
21. Phone number <input type="checkbox"/> Work <input type="checkbox"/> Home <input type="checkbox"/> Cell () -		22. Other phone number <input type="checkbox"/> Work <input type="checkbox"/> Home <input type="checkbox"/> Cell () -	
23. Fax number () -	24. Email address		

STEP 3

List all employees who will get an offer of coverage even if they may not enroll.

Please print clearly. You must include all full-time employees (30+ hours) in order to be eligible.


Call the Small Business Hotline at 1-855-499-9800 with any questions.

Employer name	Federal Employer Identification Number (EIN)
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Employee first name, middle name, last name & suffix	Employment status*	Date of hire (mm/dd/yyyy)
1.		
2.		
3.		
4.		
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23.		
24.		
25.		

*Enter employment or other participant status: full-time, part-time, owner/business partner, employed family member, COBRA, VIPER, or retired.

*While sole proprietors, their employee family members and business partners are not counted as employees, they may participate in the group plan.

 NEED HELP WITH YOUR APPLICATION? Contact a navigator or 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.

STEP 4

Read and sign this application.

- 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 Vermont Health Connect if anything changes (or is different than) what I wrote on this application. I can visit 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. 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 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. Unsigned applications will not be processed and will be returned for a signature.
Not signing the application may delay health coverage.

Signature

Date (mm/dd/yyyy)

STEP 5

Mail the completed and signed application.

Mail this completed and **signed** application to Vermont Health Connect at:

Vermont Health Connect
280 State Drive
Waterbury, VT 05671-8100

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

Voter Registration

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

If you do not check either box, you will be considered to have decided not to register to vote at this time. Applying to register or declining to register to vote will not affect your eligibility for benefits or amount granted to you by this agency. If you would like help in filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private. If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the *Secretary of State's Office* at 128 State Street, Montpelier, VT 05633-1101, or call 1-802-828-2363.