



STEP 1

Tell us about the business 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 credit.

1. Business 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)

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

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 VermontHealthConnect.gov. Relay services for the deaf **711**.

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.

Business name	Federal Employer Identification Number (EIN)
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Employee first name, middle name, last name & suffix	Date of birth (mm/dd/yyyy)	Social Security number/ Tax ID Number	Email address	Employment status*	Date of hire (mm/dd/yyyy)
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
15.					
16.					
17.					
18.					
19.					
20.					
21.					
22.					
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.

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 **VermontHealthConnect.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**.
- 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.
- 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.

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
103 South Main Street
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.

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.

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