MASSACHUSETTS HEALTH CONNECTOR
the right place for the right plan

Employee Application

Business Express

You can use this application to enroll you and your family in health or dental insurance that your employer is offering though the Massachusetts Health Connector's Business Express program.

This application should only take **5 to 10 minutes** to complete.

If you need help with this application:	▪ Ask your **employer**. ▪ Call our Customer Service at **1-888-813-9220** or TTY: 1-888-213-8163.
What kind of insurance can you apply for?	It depends on the kind of insurance your employer chooses to offer. It may be health insurance, dental insurance, or both.
What if you don't want insurance through your employer?	If you don't want the insurance that your employer offers, go to Step 4 to waive health insurance coverage and Step 5 to waive coverage for dental insurance. Then go to Step 6 to sign the application.
What's the next step?	After you've completed and signed this application, return it to your employer. Your employer will send it to us.
You may qualify for additional help:	If your share of the cost of employee-only, **health** insurance coverage (not including dental) is more than 9.5% of your household income, you may get help paying for **health** insurance. Visit **MAhealthconnector.org** to learn more.

STEP 1 Who is your employer? *If you see this * it means you are required to answer.*

Company name *	Company ID number *Ask your employer.*

STEP 2 Tell us about you, the employee. *If you see this * it means you are required to answer.*

First name * | Middle name | Last name * | Suffix

Social Security number or Tax ID number *	Date of birth *(month/day/year)* *	Are you * ☐ Male ☐ Female

If age 18 or over, do you use tobacco products? *

☐ Yes ☐ Yes, but I participate in a cessation or wellness program ☐ No

Home address * *Cannot be a PO Box*	Unit or apartment number

City *	State *	ZIP code *

Phone number ☐ Home ☐ Work ☐ Cell	Email address *

▶ For health insurance only

If you are applying for health insurance, please tell us about your primary care provider (PCP).
See the insurer's website to make sure that your PCP is included in the plan, or to choose a new PCP.

Name of PCP *

PCP ID number *	Are you a current patient of this PCP? * ☐ Yes ☐ No

PCP Address *

City *	State *	ZIP code *

STEP 3

Tell us about family members whom you would like to include in your insurance coverage.

If you don't have a spouse or dependents, you don't need to fill out this section.

- To qualify, a family member must be a spouse or a dependent; for example,
  - A legal spouse, civil union partner, domestic partner, or divorced or separated spouse, ***or***
  - A person under age 26 who is the child, stepchild, legally adopted child, or adopted child of the applicant or spouse, or a child for whom the applicant or spouse is the court-appointed legal guardian.
- If your employer offers dental coverage and you want it, you may choose to include or not include your family members in that coverage. However, with the exception of pediatric-only coverage, *you* must always be included in the coverage.
- If you have questions, talk to your employer, visit **MAhealthconnector.org** or call Customer Service at **1-888-813-9220** or TTY: 1-888-213-8163.

SPOUSE

*If you see this * it means you are required to answer.*

First name * | Middle name | Last name * | Suffix

Social Security number or Tax ID number | Date of birth * | Is this person * ☐ Male ☐ Female

☐ Do not include this person in dental coverage.

If age 18 or over, does this person use tobacco products? *
☐ Yes ☐ Yes, but he or she participates in a cessation or wellness program ☐ No

Home address * *If different from the employee. Cannot be a PO Box.* | Unit or apartment number

City * | State * | ZIP code *

Phone number ☐ Home ☐ Work ☐ Cell | Email address

▶ For health insurance only

If you are applying for health insurance, please tell us about your primary care provider (PCP).
See the insurer's website to make sure that your PCP is included in the plan, or to choose a new PCP.

Name of PCP *

PCP ID number * | Are you a current patient of this PCP? * ☐ Yes ☐ No

PCP Address *

City * | State * | ZIP code *

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STEP 3

Tell us about family members who need insurance. *(continued)*
If you have more than 4 dependents, make a copy of this blank page.

DEPENDENT 1

*If you see this * it means you are required to answer.*

First name * | Middle name | Last name * | Suffix

Social Security number or Tax ID number	Date of birth *	Is this person * ☐ Male ☐ Female

☐ Do not include this person in dental coverage.

If age 18 or over, does this person use tobacco products? *
☐ Yes ☐ Yes, but he or she participates in a cessation or wellness program ☐ No

Home address * *If different from the employee. Cannot be a PO Box.*		Unit or apartment number
City *	State *	ZIP code *
Phone number ☐ Home ☐ Work ☐ Cell	Email address	

▶ **For health insurance only**

If you are applying for health insurance, please tell us about your primary care provider (PCP).
See the insurer's website to make sure that your PCP is included in the plan, or to choose a new PCP.

Name of PCP *

PCP ID number *	Are you a current patient of this PCP? * ☐ Yes ☐ No

PCP Address *

City *	State *	ZIP code *

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STEP 3 Tell us about family members who need insurance. *(continued)*

DEPENDENT 2

*If you see this * it means you are required to answer.*

First name * | Middle name | Last name * | Suffix

Social Security number or Tax ID number | Date of birth * | Is this person * ☐ Male ☐ Female

☐ Do not include this person in dental coverage.

If age 18 or over, does this person use tobacco products? *

☐ Yes ☐ Yes, but he or she participates in a cessation or wellness program ☐ No

Home address * *If different from the employee. Cannot be a PO Box.* | Unit or apartment number

City * | State * | ZIP code *

Phone number ☐ Home ☐ Work ☐ Cell | Email address

▶ For health insurance only

If you are applying for health insurance, please tell us about your primary care provider (PCP).
See the insurer's website to make sure that your PCP is included in the plan, or to choose a new PCP.

Name of PCP *

PCP ID number * | Are you a current patient of this PCP? * ☐ Yes ☐ No

PCP Address *

City * | State * | ZIP code *

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STEP 3 Tell us about family members who need insurance. *(continued)*

DEPENDENT 3

*If you see this * it means you are required to answer.*

First name * | Middle name | Last name * | Suffix

Social Security number or Tax ID number | Date of birth * | Is this person * ☐ Male ☐ Female

☐ Do not include this person in dental coverage.

If age 18 or over, does this person use tobacco products? *

☐ Yes ☐ Yes, but he or she participates in a cessation or wellness program ☐ No

Home address * *If different from the employee. Cannot be a PO Box.* | Unit or apartment number

City * | State * | ZIP code *

Phone number ☐ Home ☐ Work ☐ Cell | Email address

▶ For health insurance only

If you are applying for health insurance, please tell us about your primary care provider (PCP).
See the insurer's website to make sure that your PCP is included in the plan, or to choose a new PCP.

Name of PCP *

PCP ID number * | Are you a current patient of this PCP? * ☐ Yes ☐ No

PCP Address *

City * | State * | ZIP code *

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STEP 3 **Tell us about family members who need insurance.** *(continued)*

DEPENDENT 4 *If you see this * it means you are required to answer.*

First name * | Middle name | Last name * | Suffix

Social Security number or Tax ID number	Date of birth *	Is this person * ☐ Male ☐ Female

☐ Do not include this person in dental coverage.

If age 18 or over, does this person use tobacco products? *
☐ Yes ☐ Yes, but he or she participates in a cessation or wellness program ☐ No

Home address * *If different from the employee. Cannot be a PO Box.*		Unit or apartment number
City *	State *	ZIP code *

Phone number ☐ Home ☐ Work ☐ Cell	Email address

▶ **For health insurance only**

If you are applying for health insurance, please tell us about your primary care provider (PCP).
See the insurer's website to make sure that your PCP is included in the plan, or to choose a new PCP.

Name of PCP *

PCP ID number *	Are you a current patient of this PCP? * ☐ Yes ☐ No

PCP Address *

City *	State *	ZIP code *

STEP 4 If your employer offers health coverage, do you want it?

☐ Yes. ***If yes,*** what kind of insurance do you want?

☐ Self ☐ Self and spouse ☐ Self and dependents ☐ Family

☐ No. I'm waiving my offer of health coverage through my employer.

If no, *tell us why you're waiving coverage:*

☐ I have insurance through my spouse.
☐ I have insurance through my parent or guardian.
☐ I have insurance though Medicare.
☐ I have insurance through Medicaid or CHIP.
☐ I have insurance through a Health Connector plan.
☐ I am waiving coverage for other reasons.
☐ I have student health insurance coverage.
☐ I have foreign health coverage.
☐ I have refugee medical assistance.
☐ I have other government-sponsored insurance.

STEP 5 If your employer offers dental coverage, do you want it?

☐ Yes. ***If yes,*** what kind of insurance do you want?

☐ Self ☐ Self and spouse ☐ Self and dependents ☐ Family

☐ No. I'm waiving my offer of dental coverage through my employer.

If no, *tell us why you're waiving coverage:*

☐ I have insurance through my spouse.
☐ I have insurance through my parent or guardian.
☐ I am waiving coverage for other reasons.
☐ I have coverage from another source.
☐ I am a part-time employee.

STEP 6 Sign and date this application. *If you see this * it means you are required to answer.*

- I have provided truthful answers to all of the questions on this form to the best of my knowledge. I know that if I'm not truthful there may be a penalty.
- I know that the information on this form will only be used to decide if I qualify for health or dental insurance and will be kept private, as required by law.
- I know that I must tell the Health Connector if anything changes or is different from what I wrote on this application. I can call Customer Service at **1-888-813-9220** or TTY: 1-888-213-8163 to report changes.

Print name *	Company name *
Signature *	Date *(month/day/year)* *

STEP 7 Return your completed and signed application to your employer.

Your employer will send us your application and provide you with additional details about your insurance coverage.