Appendix A:
List of Questions in the Small Business Health Options Program (SHOP) Online Application for Employees

Contents

I. My account

Note to reviewers: To access the SHOP online application, the employee must first set up "My account." There are two parts to setting up "My account." The employee will first create a "lite account" which gives quick access to the SHOP. They'll be able to use this to access or update their contact information, set communication preferences, get notices, and find out about coverage in a secure environment. When the employee wants to start a SHOP application for coverage, they'll be asked for more information to transition to a regular account. Part of the account creation and application process is for the employee to establish identity via an authentication process. This includes entering some personal information and answering a set of "challenge" questions. We aren't providing the list of challenge questions in order to protect the security and integrity of the system. The employee is then able to start the employee application process from within "My account."

A. Create a lite account

(Display for users setting up an account. A full account is required to create and submit an application.)

1. Create account *(Display check box.)*
    a. Name:
        i. First name: _____
        ii. Middle name: _____ *optional*
        iii. Last name: _____
        iv. Suffix: *(Display dropdown menu of suffixes.) optional*
            1. Jr.
            2. Sr.
            3. III
            4. IV
    b. Email address: _____
    c. Confirm email address: _____
    d. Username: _____
    e. Password: _____
    f. Confirm password: _____
    g. Security questions: *(Choose 4 sets from a selection of questions.)*
    h. Security question answers: *(Answers to the 4 questions provided by the individual.)*

B. Transition to a full account

(Display for user's additional account creation information.)

1. Create account *(Display check box. Information that was provided when creating a lite account will be prepopulated.)*
    a. Name:
        i. First name: _____
        ii. Middle name: _____ *optional*
        iii. Last name: _____
        iv. Suffix: *(Display dropdown menu of suffixes.) optional*
            1. Jr.
            2. Sr.
            3. III
            4. IV

b. Date of birth: MM/DD/YYYY
c. Address:
    i. Street address: _____
    ii. Apartment or suite number: _____
    iii. City: _____
    iv. State: *(Display dropdown menu of states.)*
    v. ZIP code: _____
d. Phone number: (___) ___-____ Ext. ___ *optional*
e. Second phone number: (___) ___-____ Ext. ___ *optional*
f. Email address: _____
g. Social Security number (SSN) or Tax ID: _____ *optional*

2. Authentication process *(This process includes TBD challenge questions.)*

C. Account settings

(User may select text or email as a method to receive notifications, notices, and marketing emails from his/her "My account." The user can also select his/her preferred spoken and written languages.)

D. Add authorized user

(The primary account holder may add one or more authorized users to his/her account and assign privileges.)

1. Secondary account holder

(The primary account holder may select another individual on the application to be a secondary account holder and give them permission to view or edit the application. To do this, the primary account holder can provide the secondary account holder's Marketplace account username or email address. For the authority to be official, the secondary account holder will receive an email requiring sign-in to his/her Marketplace account. If the individual doesn't have an existing Marketplace account, the primary account holder can indicate that he/she should receive an email with instructions for setting up a Marketplace account. The primary account holder must also check the box to indicate agreement to the statement below.)

a. By clicking here, I hereby agree to allow the selected party to act on my behalf to the extent I've identified. I understand that this person will have access to my personal identifying information and all information contained in an application I submit through the Marketplace. *(Display check box.)*

2. Authorized representative

(The primary account holder may choose any person to be his or her authorized representative. Both the primary account holder and authorized representative must have a "My account" and have their identity authenticated. The primary account holder designates an authorized representative by entering the authorized representative's Marketplace username or associated email when prompted. If the authorized representative doesn't have a username, the primary account holder will be asked to enter the authorized representative's email address. The system then sends an email to the authorized representative for confirmation.

An individual can also create an account on someone else's behalf by opting to become an authorized representative. The individual will be asked to upload proof of authorized representation status. Once the documentation is verified, that person can act as an authorized representative for the primary account holder.)

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."

a. Do you want to name someone as your authorized representative? *optional*
    i. Yes *(If selected, continue to "b.")*
    ii. No *(If selected, skip to section II ["Privacy"].)*
b. Does this person already have their own Marketplace account?
    i. Yes *(If selected, display "1.")*
        1. Enter the username or email address for this person's account. You can enter one or both below. (*Allow entries in one or both fields, then continue to "c.")*
            a. Username: _____
            b. Email address: _____
    ii. No *(If selected, display "1.")*
        1. This person will need to create a Marketplace account in order to get notices and act on your behalf. Enter his or her email address below. We'll send information on how to create an account and become your authorized representative. You can still continue with your application now.
            a. Email address: _____
            b. Re-enter email address: _____
c. Is this person part of an organization helping you apply for health coverage? *(If "ii" ("no") was selected in "b" above, display "optional.")*
    i. Yes *(If selected, display "1-2," then continue to "d.")*
        1. Organization name: _____
        2. Organization ID: _____
    ii. No
d. *(If the individual is incapacitated and unable to complete the process of logging in to create a user account and identify an authorized user, an authorized representative can submit paper documentation proof of authority to act on behalf of the individual. The authorized representative must upload the document into "My account" for review.)*
    i. If someone is representing the applicant because he or she has a power of attorney or court order, upload the document.
    (Display dropdown menu of document types.)
        1. Power of attorney
        2. Court order establishing legal guardianship
        3. CMS form to appoint an authorized representative
    ii. (Select file for upload.)

3. *(The primary account holder then agrees to the statement below by checking the box.)*

By clicking here, I hereby agree to allow the selected party to act on my behalf to the extent I've identified. I understand that this person will have access to my personal identifying information and all information contained in an application I submit through the Marketplace. *(Display check box.)*

E. Change in circumstances

(Display section if the user previously completed an application and now indicates that he/she wants to report a change.)

1. Do you want to report a change in circumstances that may qualify you or your dependents for a Special Enrollment Period? Click here to see the changes you need to tell us about. *(Display link to help text that lists potential changes.)*
   a. Yes *(If selected, display user's prepopulated application, and allow edits.)*
   b. No

Note to reviewers: Once a user has set up an account, he or she can proceed along the application process, which begins with section II ["Privacy"].

II. Privacy

(Display this section for all applicants.)

A. Privacy & use of your information

1. We'll 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 in the SHOP, and to help you enroll.

2. I have consent from everyone I'll list on the application to include their personally identifiable information, like dates of birth, Social Security numbers, addresses, and phone numbers. *(Display check box.)*

III. Verify your information

(Display these items for all applicants.)

1. Enter the SHOP employer code given to you by your employer: _____
2. Social Security number (SSN) or tax ID number: _____ *(Prepopulate with any previously provided information, and allow editing.)*
3. The following information either wasn't entered when you started your account or may have been provided by your employer. Provide updates if necessary. *(Prepopulate with any previously provided information, and allow editing.)*
   i. Middle name: _____ *optional*
   ii. Suffix *(Display dropdown menu of suffixes.) optional*
      1. Jr.
      2. Sr.
      3. III
      4. IV
   iii. Date of birth: MM/DD/YYYY

4. Are you getting help from a navigator or other assistor? Note: Don't include information about your employer's agent or broker. If your employer is using an agent or broker, we already have that information.
    a. Yes *(If selected, display "i-iii.")*
        i. Name:
            1. First name: _____
            2. Middle name: _____ *optional*
            3. Last name: _____
            4. Suffix *(Display dropdown menu of suffixes.) optional*
                a. Jr.
                b. Sr.
                c. III
                d. IV
        ii. Organization name: _____
        iii. FFM User ID: _____
    b. No

Note to reviewers: The employer must meet a minimum participation rate of employees who intend to accept SHOP coverage. Section IV ["Sources of coverage"] collects information about each employee's intent to participate, as well as other coverage the employee may already have. At this point, the employee doesn't see any details about costs or coverage associated with the employer's SHOP plan(s).

IV. Sources of coverage

1. Will you have other sources of health coverage once this employer's SHOP plan is effective?
    a. Yes *(Display check box. If selected, continue to item 2.)*
    b. No *(Display check box. If selected, skip to section V ["Employee information"].)*

2. *(Display this item if "a" was selected in item 1.)*
   I will have other health coverage through: *(Display dropdown menu of coverage options.)*
    a. Individual private health insurance
    b. Insurance from another job
    c. Insurance through another person's job
    d. Medicare
    e. Medicaid
    f. TRICARE
    g. VA health care programs
    h. Indian Health Service

3. Do you want to learn more about your employer's offer of health coverage or any offered dental coverage?
    a. Yes. I want to learn more. If I accept my employer's offer of health coverage, I'll use my other source of coverage as supplemental insurance. *(Display check box. If selected, display "i-ii.")*
        i. Name of health insurance company: _____
        ii. Policy ID number: _____
    b. No. I want to decline coverage through my employer's plan. *(Display check box. If selected, display "i.")*

i. I'm declining my employer's offer of health coverage and any offered dental coverage. I fully understand that I'm choosing to decline this employer's offer to provide health coverage and any offered dental coverage. If this employer is offering coverage for my dependents, I'm choosing to decline that offer of coverage, too. *(Display check box. If selected skip to section X ["Review & sign"].)*

V. Employee information

(Display this section for all applicants. Prepopulate with information from "My account," and allow editing.)

A. Information about you

1. Home address:
   a. Street address: _____
   b. Apartment or suite number: _____
   c. City: _____
   d. State: *(Display dropdown menu of states.)*
   e. ZIP code: _____

2. Mailing address:
   a. Check here if your mailing address is the same as your home address. *(Display check box.) (If selected, populate "b-f" with information from home address.)*
   b. Street address: _____
   c. Apartment or suite number: _____
   d. City: _____
   e. State: *(Display dropdown menu of states.)*
   f. ZIP code: _____

3. Phone number: (___) ___-____ Ext. ____

4. Phone type: (Select one.) *(Display dropdown menu of phone types.)*
   a. Cell
   b. Home
   c. Work

5. Second phone number: (___) ___-____ Ext. _____ *optional*

6. Second phone type: (Select one.) *(Display dropdown menu of phone types.)*
   a. Cell
   b. Work
   c. Home

7. Email address: _____

8. Contact preferences:
   a. Preferred spoken language: *optional*

i. *(Display dropdown list of languages; default to English.)*

b. Preferred written language: *optional*
   i. *(Display dropdown list of languages; default to English.)*

c. You'll be contacted when a notice is ready for you on this website. How can we contact you? *(Display check boxes.)*
   i. Text: *(Prepopulate phone number. If selected, display "1.")*
      1. Messaging rates will apply.
   ii. Email: *(Prepopulate email.)*

d. Do you also want to get paper notices in the mail?
   i. Yes. I want to get paper notices sent to me in the mail.
   ii. No. I don't want to get paper notices sent to me in the mail.

9. Within the past 6 months, have you used tobacco regularly (4 or more times per week on average)? Don't count religious or ceremonial uses.
   a. Yes *(If selected, continue to item 10.)*
   b. No *(If selected, skip to subsection "B" ["Demographic information"].)*

10. *(Display item if "a" was selected in item 9.)*
    When was the last time you used tobacco regularly?
    a. Date: MM/DD/YYYY *(Continue to item 11.)*

11. *(Display item if "a" was selected in item 9.)*
    Do you plan to complete a tobacco cessation program for tobacco users offered by the health plan?
    a. Yes. I understand that my premiums won't include the tobacco surcharge of up to 50%, which can be billed to me if I don't complete the program. *(Display check box.)*
    b. No. I understand that my premiums will include a tobacco surcharge if the health plan charges one. *(Display check box.)*

B. Demographic information

1. Sex:
   a. Male *(Display check box.)*
   b. Female *(Display check box.)*

2. Are you of Hispanic, Latino, or Spanish origin? *optional*
   a. Yes *(Display check box. If selected, display "i.")*
      i. Ethnicity: (Check all that apply.)
      (Display check boxes.)
         1. Cuban
         2. Mexican, Mexican American, or Chicano/a
         3. Puerto Rican
         4. Other: _____
   b. No

3. Race: (Check all that apply.) *optional*
   (Display check boxes.)
   a. American Indian or Alaska Native

b. Asian Indian
c. Black or African American
d. Chinese
e. Filipino
f. Guamanian or Chamorro
g. Japanese
h. Korean
i. Native Hawaiian
j. Other Asian
k. Other Pacific Islander
l. Samoan
m. Vietnamese
n. White
o. Other: _____

VI. Dependents

(Display for all applicants whose employer has elected to offer dependent coverage.)

1. If you enroll, will you add dependents to your policy?
   a. Yes *(If selected, display "i.")*
      i. How many dependents want coverage?
         1. __ *(Display dropdown; default to 0.)*
   b. No *(If selected, skip to section VII ["Review employer's health plan"].)*

2. *(Display for each dependent.)*
   Dependent [sequence of dependent entry] of [total dependent number indicated]:
   a. Name:
      i. First name: _____
      ii. Middle name: _____ *optional*
      iii. Last name: _____
      iv. Suffix *(Display dropdown menu of suffixes.) optional*
         1. Jr.
         2. Sr.
         3. III
         4. IV
   b. Social Security number (SSN) or tax ID number: _____
   c. Date of birth: MM/DD/YYYY
   d. Relationship to you: *(Display dropdown of relationships that are allowed for plan enrollment and available in the state.)*
      i. Husband/wife
      ii. Domestic partner
      iii. Parent
      iv. Stepparent
      v. Parent's domestic partner
      vi. Son/daughter
      vii. Stepson/stepdaughter
      viii. Child of domestic partner

ix. Brother/sister
x. Stepbrother/stepsister
xi. Uncle/aunt
xii. Nephew/niece
xiii. First cousin
xiv. Grandparent
xv. Grandchild
xvi. Other *(If selected, display dropdown of relationships that are allowed for plan enrollment and available in the state.)*
    1. Adopted son/daughter
    2. Foster child
    3. Former spouse
    4. Guardian
    5. Court-appointed guardian
    6. Collateral dependent
    7. Sponsored dependent
    8. Dependent of a minor dependent
    9. Ward
    10. Other relative
    11. Unrelated

3. *(Display for each dependent.)*
   Within the past 6 months, has [Dependent name] used tobacco regularly (4 or more times per week on average)? Don't count religious or ceremonial uses.
   a. Yes *(If selected, continue to item 4.)*
   b. No *(If selected, skip to item 6.)*

4. *(Display if "a" was selected in item 3.)*
   When was the last time [Dependent name] used tobacco regularly?
   a. Date: MM/DD/YYYY *(Continue to item 5.)*

5. *(Display if "a" was selected in item 3.)*
   Does [Dependent name] plan to complete a tobacco cessation program for tobacco users offered by the health plan?
   a. Yes. I understand my premiums won't include a tobacco surcharge of up to 50%, which can be billed to me if this dependent doesn't complete the program. *(Display check box.)*
   b. No. I understand that my premiums will include a tobacco surcharge if the health plan charges one. *(Display check box.)*

6. [Dependent name]'s sex:
   a. Male *(Display check box.)*
   b. Female *(Display check box.)*

7. Is [Dependent name] of Hispanic, Latino, or Spanish origin? *optional*
   a. Yes *(If selected, display "i.")*
      i. Ethnicity: (Check all that apply.)

(Display check boxes.)

1. Cuban
2. Mexican, Mexican American, or Chicano/a
3. Puerto Rican
4. Other: _____

b. No

8. [Dependent name]'s race: (Check all that apply.) *optional*
   a. American Indian or Alaskan Native
   b. Asian Indian
   c. Black or African American
   d. Chinese
   e. Filipino
   f. Guamanian or Chamorro
   g. Japanese
   h. Korean
   i. Native Hawaiian
   j. Other Asian
   k. Other Pacific Islander
   l. Samoan
   m. Vietnamese
   n. White
   o. Other: _____

9. [Dependent name]'s preferred spoken language:
   a. *(Display dropdown list of languages; default to English.)*

10. [Dependent name]'s preferred written language:
    a. *(Display dropdown list of languages, default to English.)*

11. Will [Dependent name] have other health coverage at the same time as this coverage?
    a. Yes *(If selected, display "i-ii.")*
       i. Name of health insurance company: _____
       ii. Policy ID number: _____
    b. No

12. Does [Dependent name] have a different mailing address than you?
    a. Yes *(If selected, display "i.")*
       i. Mailing address: _____
          1. Street address: _____
          2. Apartment or suite number: _____ *optional*
          3. City: _____
          4. State: *(Display dropdown menu of states.)*
          5. ZIP code: _____
    b. No

(Repeat items 2-3 and 6-12 for each dependent; display items 4-5 only if applicable based on response given in item 3.)

VII. Review employer's health plan

Note to reviewers: When SHOP enrollment begins, most employers will be able to offer their employees coverage with a single health plan and a single dental plan. In some states, employers may offer employees a choice of health and dental plans. This section shows different functions for reviewing and accepting an employer's offer of coverage. Subsection "A" displays when the employer offers one health plan to the employee. The employee can check cost and coverage information and decide if he/she wants to enroll or decline coverage. Subsection "B" offers the same type of actions, but displays when the employer offers a choice of different health plans to the employee.

A. The employer health coverage offered to you

(Display subsection "A" if employer selected a single plan. Display prepopulated health plan name, employer contribution amount, and information.)

1. Will you accept this health coverage?
    a. Yes. I plan to accept this coverage through my employer. *(Display check box. If selected and applicant entered dependent information, display "i." If selected, applicant didn't enter dependent information, and employer offers standalone dental coverage, skip to section VIII ["Review employer's dental plan"]. If selected outside of the open enrollment period, and employer doesn't offer standalone dental coverage, skip to section IX ["Special circumstances"]. If selected and none of the above apply, skip to section X ["Review & sign"].)*
        i. Which dependents would you like to have coverage? *(Display name and check box for each dependent. If any dependents were selected, and employer offers standalone dental coverage, skip to section VIII ["Review employer's dental plan"]. If selected outside of the open enrollment period, skip to section IX ["Special circumstances"]. If selected and neither of the previous apply, skip to section X ["Review & sign"].)*
    b. No. I waive this coverage through my employer. *(Display check box. If selected, display "i.")*
        i. Are you sure you want to decline this coverage? *(Display radio buttons.)*
            1. Yes. I want to decline this coverage. *(If selected and employer doesn't offer standalone dental coverage, skip to section X ("Review & sign"]. If selected and employer offers standalone dental coverage, skip to section VIII ["Review employer's dental plan"].)*
            2. I'm not sure. I want to find out more about this health plan. *(If selected, display prepopulated plan information from the beginning of this subsection.)*
    c. I'm not sure. I want to find out more about this health plan. *(Display check box. If selected, display prepopulated plan information from the beginning of this subsection.)*

B. The employer health coverage offered to you

(Display subsection "B" if employer selected a plan category (metal level). Display prepopulated plan category (metal level), sample plan information, and employer contribution amount.)

1. Will you accept health plan coverage?
    a. Yes. I plan to accept coverage through my employer. *(Display check box. If selected and applicant entered dependent information, display "i-iii." If dependent coverage isn't offered, display only "ii-iii.")*
        i. Which dependents would you like to have coverage? *(Display name and check box for each dependent.)*
        ii. *(Display comparison tools and available plans within plan category (metal level).)*
        iii. Enroll *(Applicant reviews and selects a plan. Display "enroll" button next to plans. If selected and employer offers standalone dental coverage, continue to section VIII ["Review employer's dental plan"]. If selected outside the open enrollment period and employer doesn't offer standalone dental coverage, skip to section IX ["Special circumstances"]. If neither of the previous applies, skip to section X ["Review & sign"]. If after reviewing the plans, the employee doesn't want any of the plans, they can edit this selection to indicate that they don't want to accept coverage.)*
    b. No. I want to waive this coverage through my employer *(Display check box. If selected, display "i.")*
        i. Are you sure you want to decline this coverage? *(Display radio buttons.)*
            1. Yes. I want to decline this coverage. *(If selected and employer doesn't offer standalone dental coverage, skip to section X ["Review & sign"]. If employer offers standalone dental coverage, continue to section VIII ["Review employer's dental plan(s)"].)*
            2. I'm not sure. I want to find out more about the health plans offered by my employer. *(If selected, display comparison tools and available plans within plan category (metal level).)*
    c. I'm not sure. I want to find out more about the health plans offered by my employer. *(Display check box. If selected, display comparison tools and available plans within plan category (metal level).)*

VIII. Review employer's dental plan

Note to reviewers: When SHOP enrollment begins, most employers will be able to offer their employees coverage with a single health plan and a single dental plan. In some states, employers may offer employees a choice of health and dental plans. This section shows different functions for reviewing and accepting an employer's offer of dental coverage. Subsection "A" displays when the employer offers one dental plan to the employee. The employee can check cost and coverage information and decide if he/she wants to enroll or decline coverage. Subsection "B" offers the same type of actions, but displays when the employer offers a choice of different dental plans to the employee.

A. The employer dental plan offered to you

(Display subsection if employer elected to offer a standalone dental plan. Display subsection "A" if employer has selected a single plan. Display prepopulated dental plan name, employer contribution amount, and information.)

1. Will you accept this dental plan coverage?
    a. Yes. I plan to accept this dental coverage through my employer. *(Display check box. If selected and applicant added dependent information, display "i." If selected outside of*

the open enrollment period and dependent coverage isn't offered, skip to section IX ["Special circumstances"]. If selected and neither of the previous applies, skip to section X ["Review & sign"].)

i. Which dependents would you like to have coverage? *(Display name and check box for each dependent. If selected outside of the open enrollment period, skip to section IX ["Special circumstances"]. Otherwise, skip to section X ["Review & sign"].)*

b. No. I want to waive this coverage through my employer. *(Display check box. If selected, display "i.")*

i. Are you sure you want to decline this coverage? *(Display radio buttons.)*

1. Yes, I want to decline this coverage. *(If selected, skip to section X ("Review & sign").)*
2. I'm not sure. I want to find out more about this dental plan. *(If selected, display prepopulated dental plan information from the beginning of this subsection.)*

c. I'm not sure. I want to find out about more about this dental plan. *(Display check box. If selected, display prepopulated dental plan information from the beginning of this subsection.)*

B. The employer dental plan options offered to you

(Display subsection if employer elected to offer a standalone dental plan. Display subsection "B" if employer has selected 2 dental plan options. Display dental plans, employer contribution amount, and information.)

1. Will you accept this dental plan coverage?
   a. Yes. I plan to accept this dental coverage through my employer. *(Display check box. If selected and user entered dependent information, display "i-iii." If dependent coverage isn't offered, display only "ii-iii.")*
      i. Which dependents would you like to have dental coverage? *(Display name and check box for each dependent.)*
      ii. *(Display comparison tools and available plans.)*
      iii. Enroll *(Applicant reviews and selects a plan. Display "enroll" radio button next to plans. If selected outside the open enrollment period, continue to section IX ["Special circumstances"]. Otherwise, if selected, skip to section X ["Review & sign"].*
   b. No. I want to waive this dental coverage through my employer. *(Display check box. If selected, display "i.")*
      i. Are you sure you want to decline this dental coverage? (*Display radio buttons.)*
         1. Yes. I want to decline this coverage. *(If selected, skip to section X ["Review & sign].)*
         2. I'm not sure. I want to find out more about the dental plans offered by my employer. *(If selected, display comparison tools and available plans.)*
   c. I'm not sure. I want to find out more about the dental plans offered by my employer. *(Display check box. If selected, display comparison tools and available plans.)*

IX. Special circumstances

(Display section if indicated through "My account" or if enrolling outside of open enrollment.)

A. American Indian/Alaska Native

1. Are any of these people a member of a federally recognized tribe?
   (Display applicants' names with radio buttons for each, and allow multi-select.)
   a. Yes
   b. No

2. *(Display item if "a" was selected for one or more individuals in item 1.)*
   Select a state and tribe.
   a. State: *(Display dropdown menu of states.)*
   b. Tribe name: *(Display list of tribe names.)*

3. *(Display item if "a" was selected for one or more of the individuals in item 1.)*
   Who is a member of the [Name of tribe] tribe?
   a. *(Display list of all eligible individuals with check boxes.)*
   b. All of the above

4. *(Display item if "a" was selected for one or more individuals in item 1.)*
   a. Upload tribal membership proof *optional (Display "select file to upload" button. Also display filename and "remove file" buttons.)*
   b. I'll send proof by mail *optional*

(Display items 2-4 as needed to identify state and tribe for each individual identified as AI/AN in this subsection, item 1.)

B. Changes in the last 30 days

Note to reviewers: These questions display when the applicant returns to a submitted application and reports a change in circumstances that may allow a Special Enrollment Period. Before responding to the items below, the applicant must first view and edit (as needed) the prepopulated information in section VI ["Dependents"] and add any new dependents (i.e. spouse, baby, child).

(Display within the prepopulated application if applicant indicated a change in circumstances in section I ["My account"], subsection "E" ["Change in circumstances"], item 1, "a" ("Yes").)

1. Within the last 30 days:
   a. Did you or any of your dependents lose eligibility for coverage under a group health plan?
      i. Yes *(Display check box. If selected, continue to item 2.)*
      ii. No *(Display check box.)*
   b. Did you get married?
      i. Yes *(Display check box. If selected, skip to item 3.)*
      ii. No *(Display check box.)*
   c. Did you or any of your dependents need to change coverage because of a move?
      i. Yes *(Display check box. If selected, skip to item 4.)*

ii. No *(Display check box.)*

d. Did you adopt someone?
   i. Yes *(Display check box. If selected, skip to item 5.)*
   ii. No *(Display check box.)*

e. Did you have a baby?
   i. Yes *(Display check box. If selected, skip to item 6.)*
   ii. No *(Display check box.)*

2. *(Display item if "i" was selected in item "1.a.")*
   In the last 30 days, which of these people lost health coverage? (Check all that apply.)
   (Display name with check box for enrollee and each dependent. If selected, display "a-b.")
   a. When did [Name] lose health coverage?
      i. Date: MM/DD/YYYY
   b. Did [Name] lose health coverage because [he/she] didn't pay premiums?
      i. Yes
      ii. No

3. *(Display item if "i" is selected in item "1.b.")*
   a. When did you get married?
      i. Date: MM/DD/YYYY

4. *(Display item if "i" is selected in item "1.c.")*
   In the last 30 days, did any of these people move? (Check all that apply.) *(Display name with check box for enrollee and each dependent. If selected, display "a-b.")*
   a. When did [Name] move?
      i. Date: MM/DD/YYYY
   b. New ZIP code: _____

5. *(Display item if "i" is selected in item "1.d.")*
   a. When did you adopt?
      i. Date: MM/DD/YYYY

6. *(Display item if "i" is selected in item "1.e.")*
   a. When did you have a baby?
      i. Date: MM/DD/YYYY

X. Review & sign

Note to reviewers: This section describes the summary and signature pages of the application, and is more focused on displaying information rather than asking questions.

A. Review application

(The user is provided with a list of all the data that they've entered in the application. They can review the details and click to navigate back to the appropriate section to make changes.)

B. Sign & submit

(Display items 1-4. Display check boxes.)

1. I know that I must tell the SHOP if information I listed on this application changes.

2. I'm signing this application under penalty of perjury, which means I've provided true answers to all 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. In addition, I know that my coverage and the coverage for my dependents (if applicable) may be impacted if I provide false or untrue information.

3. *(Display for applicant)*
   a. Electronic signature: _____

4. Following federal law, discrimination isn't 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 (hyperlink).