

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



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I. My account

Note to reviewers: To access the SHOP online application, the employee must first set up “My account.” The employee will first create an 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 including the unique participation code from their employer and their Social Security Number (SSN). 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 an account

(Display for users setting up an account.)

1. Create account *(Display check box.)*
 - a. Name:
 - i. First name: _____
 - ii. Last name: _____
 - b. Email address: _____
 - c. Password: _____
 - d. Retype password: _____
 - e. Security questions: *(Choose 4 sets from a selection of questions.)*
 - f. Security question answers: *(Answers to the 4 questions provided by the individual.)*

The user will then be prompted to verify their email address through a unique link. After the email address has been verified and the account has been created, the user will be prompted to log in to HealthCare.gov with their new username and password to accept the terms and conditions of using the FF-SHOP platform.

B. SHOP Participation Code and SSN

The system will display the following message:

Enter your participation code and Social Security Number (SSN) or Tax ID Number (TIN).

The system determines the user’s eligibility by comparing the SHOP participation code, the user’s name, and SSN entered to the information provided by the employer on the employee roster. If the information is validated, the user will be prompted to select YES or NO to add their employer to their account.

C. My Profile

Users may update their personal profile information. Fields with a * reflect required fields.

1. Basic information
 - a. First name*
 - b. Middle name
 - c. Last name*
 - d. Suffix
 - e. Account number

- f. Email address*
- g. SSN/TIN*
- h. Date of birth
- 2. Home address
 - a. Street address*
 - b. Apt/Ste. #
 - c. City*
 - d. ZIP*
 - e. County*
 - f. State*
- 3. Contact phone
 - a. Phone number
 - b. Ext.
 - c. Phone type
 - d. Second phone number
 - e. Ext.
 - f. Phone type
- 4. Contact preferences
 - a. Preferred spoken language
 - b. Preferred written language
 - c. Preferred method of contact
 - i. Email address*
 - ii. Mailing address
 - iii. Phone number*

II. Privacy

(Display this section for all applicants.)

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. Enrollment application

Users will need to verify all information before submitting their applications. Once the application is submitted, changes cannot be made. All fields from the My Profile section will appear. Additionally, the following questions will also be asked:

1. Race (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: _____
2. If of Hispanic Latino or Spanish origin, select ethnicity (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
3. Are you a member of a federally recognized tribe?
4. Within the past 6 months have you used tobacco regularly (4 or more times per week on average excluding religious or ceremonial use)?
5. Will you have other sources of health coverage once this employer's SHOP plan is effective?

IV. 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*
- c. Yes *(If selected, display "i.")*
 - i. Ethnicity: (Check all that apply.)
(Display check boxes.)
 - 5. Cuban
 - 6. Mexican, Mexican American, or Chicano/a
 - 7. Puerto Rican
 - 8. Other: _____
 - d. 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.)

V. Sources of coverage

If a user declines coverage, the user will be asked what health coverage they currently have or will have once their employer’s coverage is effective.

1. I’ll have the following health coverage once this employer’s SHOP plan is effective
 - 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

VI. Review employer’s health plan

Note to reviewers: When SHOP enrollment begins, employers will be able to offer their employees coverage with a single health plan and a single dental plan. Employers may also 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 waive 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).)*

VII. Review employer's dental plan

Note to reviewers: When SHOP enrollment begins, employers will be able to offer their employees coverage with a single dental plan. Employers may also offer employees a choice of 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.)*

VIII. 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

IX. 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).