OMB control number: 0938-1193
Expiration Date: XX/XX/20XX

CMS.gov

Get a SHOP eligibility determination here.

To be eligible to enroll in health insurance through the Small Business Health Options Program (SHOP), your small business or non-profit organization must:

- Have a primary business address in the state where you're buying coverage.
- Have at least one employee enrolling in coverage who isn't the owner, business partner, or spouse of the owner or business partner.
- Have from 1 to 50 full-time equivalent (FTE) employees.
- Offer SHOP coverage to all full-time employees.

This form will determine your eligibility for SHOP.

QUESTIONS?

https://www.healthcare.gov/contact-us/

→

CMS.gov

Business Name:

Business Email (Optional):
Don't use a personal email address unless it's the one you also use for your business.

Business Phone Number: xxx-xxx-xxxx

Business Address:

Employer Identification Number (EIN):
Enter your 9 digit number after the leading 0

0

Date current SHOP plan year began, or will begin:
mm/dd/yyyy

→

CMS.gov

To be eligible to enroll in SHOP insurance, you must indicate that your small business or non-profit organization meets all the following qualifications. Answer "Yes" or "No" to the following questions.

This business has from 1 to 50 full-time equivalent (FTE) employees or participated in SHOP last year.
Learn how to count FTE employees.

- (●) Yes
- ( ) No

←

→

CMS.gov

This business has a primary business address in the state where I'm applying for this SHOP coverage.

- (●) Yes
- ( ) No

←

→

CMS.gov

All full-time employees of my business will be offered SHOP coverage.

- (●) Yes
- ( ) No

←

→

CMS.gov

This business has at least one employee enrolling in coverage who isn't an owner or business partner, or the spouse of the owner or business partner.

- (●) Yes
- ( ) No

←

→

CMS.gov

This business is ELIGIBLE to enroll in SHOP coverage. You can enroll in a plan through an insurance company or with an agent or broker. Please confirm the information in your business' eligibility determination below.

- (•) I confirm the information about this business is correct and this business is therefore eligible for SHOP coverage.

Review your information before you click **Submit.**

Business Name: X, inc.

Business Email (optional):
Don't use a personal email address unless it's the one you also use for your business. xxx.xxxx@yyy.com

Business Address:

10 X Street, X City, X State, XXXXX
10 X Street, X City, X State, XXXXX
10 X Street, X City, X State, XXXXX
10 X Street, X City, X State, XXXXX

Employer Identification Number (EIN):
Enter your 9 digit number after the leading 0
****

Date current SHOP plan year began, or will begin:
mm/dd/yyyy
01/01/2023

This business has from 1 to 50 full-time equivalent (FTE) employees or participated in SHOP last year.
Learn how to count FTE employees.
Yes

This business has a primary business address in the state where I'm applying for this SHOP coverage. Yes

All full-time employees of my business will be offered SHOP coverage. Yes

This business has at least one employee enrolling in coverage who isn't an owner or business partner, or the spouse of the owner or business partner. Yes

Retain your eligibility determination for your records:
Your eligibility determination will be sent to the email address you provided.
If you didn't provide an email address, please be sure to print or save your responses.

← →

CMS.gov

Thank You!
You have completed your SHOP eligibility determination.

ELIGIBLE BUSINESSES

- If you're already working with an agent or broker or an insurance company. present them with your eligibility confirmation email or printed page.
- To browse SHOP plans and prices visit HealthCare.gov.
- To find a SHOP agent or broker use the Find Local Help tool.

NON-ELIGIBLE BUSINESSES:

- If you don't agree with your eligibility determination you can file an appeal.