Arizona 2021 Business Enrollment Form

Instructions

The attached forms should be completed with the assistance of your authorized Broker or Enrollment Guide. Please complete all necessary forms in their entirety. Please print in ink or type your responses and ensure that all areas requiring a signature and date are complete.

Completed enrollment application forms should be entered on the enrollment portal (business.hioscar.com) prior to your effective date. This can be completed by your Broker or an Enrollment Guide.

Required Documents

Please complete the following documents to enroll. All application data and forms must be entered into the enrollment portal at business.hioscar.com. Cigna Administered by Oscar does not accept any paper forms by mail or fax.

Arizona 2021 Business Enrollment Form
This can be completed online in the enrollment portal.

Arizona Employee Enrollment application(s)
One application should be completed for each enrolling employee or COBRA/Continuation of benefits recipient. These applications can be completed entirely online by employees - or completed on paper and then entered in the portal by the authorized Broker or GA.

Employee waiver form(s)
One form is needed for each employee waiving or refusing coverage. Waivers may be completed online in the enrollment portal.

Business Entity Document
Required for all enrolling groups to verify they're eligible to conduct business in the state of Arizona.

Payroll verification through appropriate tax documentation
A1-QRT is required for all enrolling groups, unless there are seven (7) or more eligible enrolling employees. Documents submitted must include all enrolling employees. Additional tax documentation may be required based on group type (see Underwriting Guidelines for additional information).

ACH Authorization Form
This is optional but highly encouraged to expedite member ID card delivery. ACH payments can be setup for automatic deduction on the first of every month or can be uploaded solely for an automatic first payment.

If the **group wishes to pay the first premium via check**, they must wait for approval and the first bill generation and delivery.
The **first premium check** should be **mailed** along with the bill stub and can be overnighted to the following address:

Bank of America Lockbox Services
Cigna Administered by Oscar, Insured by Cigna Health and Life Insurance Company, LockBox 412803
MA5-527-02-07
2 Morrissey Blvd.
Dorchester, MA 02125

Cigna
Administered by OSCAR

Section A: Business information

Business name		Doing business as (if applicable)	
Business address (Not P.O. Box)			
City	State	ZIP code	County
Mailing Address (if different from address above)			
Federal Tax ID number	SIC code (optional)	Nature of business	

Business classification

☐ S Corp ☐ C Corp ☐ Non-Profit ☐ Partnership ☐ LLC ☐ LLP ☐ Other (please explain):

Was this business established within the last year?

☐ No ☐ Yes If yes, date business was established (mm/dd/yyyy):

Section A.1: Business contacts (please include the person(s) responsible for managing the business' account)

First name	Last name		Job title
Email	Phone	Ext.	Fax (optional)

Is this person also the billing contact? ☐ No ☐ Yes

Is their mailing address different then the business's address? ☐ No ☐ Yes → If yes, please complete the information below:

Address		
City	State	ZIP code

Additional business contact (optional)

First name	Last name		Job title
Email	Phone	Ext.	Fax (optional)

Is this person also the billing contact? ☐ No ☐ Yes

Is their mailing address different then the business's address? ☐ No ☐ Yes → If yes, please complete the information below:

Address		
City	State	ZIP code

Section A.2: Business affiliates

If the business has any affiliates that qualify as a single employer under subsection (b), (c), (m) or (o) of the Internal Revenue Code, Section 414, please complete the information below for each affiliated entity.

Legal name	Location	Tax Identification Number (TIN)	Number of full time employees	Employees enrolling

Section A.3: Agent/producer/broker certification (to be completed by the appointed agent/broker)

1. I am not aware of any additional information not contained within this application that may have bearing on this group or any member's eligibility.
2. I have not completed any of the information contained in the application except with the permission of the applicant and as noted by my initials and date on the application.
3. I have not signed any of the applications for an employer representative or individual employee's application. If after submission of this application, I request any additions or changes to any information, I will do so only with the written consent of the applicant, and I authorize Cigna Administered by Oscar to attribute such additions or changes to me.
4. I have advised the employer that a failure to provide complete and accurate information may result in a loss of coverage retroactive to the effective date of coverage and that coverage shall not be effective until Cigna Administered by Oscar reviews and approves the application and the employer receives a written notice.
5. I am the appointed agent/broker and am receiving commissions for the submission of this client. No portion of my commission payments from Cigna Administered by Oscar shall be paid to an agent/broker/producer not appointed/approved by Cigna Administered by Oscar.
6. I have advised the client not to terminate any existing coverage until receiving written notification from Cigna Administered by Oscar that the coverage being applied for by this application is accepted.

Writing payable/sub-agent/producer/broker		**Second writing payable/sub-agent/producer/broker**	
First name	Last name	First name	Last name
Broker ID		Broker ID	
NPN (optional)		NPN (optional)	
Phone		Phone	
Email		Email	
Commission percentage (if splitting with a second broker):		Commission percentage (if splitting with a second broker):	
Signature X	Date (mm/dd/yyyy)	Signature X	Date (mm/dd/yyyy)

Section A.4: Prior carrier coverage (required)

If this plan is a total replacement of any existing group plans, please list the carrier and relevant information below:

Prior carrier name	Total replacement? (Y/N)	Start date (mm/dd/yyyy)	End date (mm/dd/yyyy)

Section B: Eligibility and enrollment[1]

Preferred effective date of coverage (mm/dd/yyyy)? Must be 1st or 15th of a future month.

Coverage offered to all eligible employees working an average of:

◯ 20+ hrs ◯ 30+ hrs

Total number of full-time equivalent (FTE) employees[2] over the previous calendar year? (including employed owners/officers and part-time employees; excluding COBRA)

Total number of eligible employees?

How many current employees will be enrolling? (excluding COBRA members)

How many eligible employees will be submitting valid waivers? At least 50% of all eligible employees must participate in the policy. Refer to Underwriting Guidelines for more detail.

Did your business have 20 or more total employees during at least 50% of the working days in the previous calendar year?[3]
(If yes, your business is subject to COBRA and Arizona State Continuation. If no, your business is subject to Arizona State Continuation of Coverage.)

☐ No ☐ Yes

Will (or did) your business have at least 20 full-time and part-time employees for at least 20 weeks in the current or last calendar year?[4]

☐ No ☐ Yes

[1] Cigna Administered by Oscar requires certain forms of proof to establish eligibility. Please contact us at 1-855-672-2784 for our details regarding eligibility categories and required forms of proof. At least one

(1) eligible, active, full-time employee must be enrolled (excluding officers/owners). Cigna Administered by Oscar reserves the right to request additional documentation to confirm number of hours worked and other relevant information when verifying group size/eligibility for participation.

[2] The FTE employee counting method in 26 U.S.C. § 4980H(c)(2) must be utilized to determine group size for medical coverage. For more information, refer to the Underwriting Guidelines.

[3] Use the FTE employee counting method described above.

[4] Include all full-time employees, part-time employees, seasonal employees, temporary employees, union workers, owners, partners and officers. Exclude self-employed persons, independent contractors (1099), directors and leased employees. Unlike the FTE counting method above, here, each included employee counts as one.

Section C: Employee medical coverage selection

Complete the following section to select plan details. Please note that in the online portal, you will have to create one "Default" class, but no more than one class. If you have any questions, please contact us at Business@hioscar.com.

Section C.1: Plan Information

Select waiting period for new employees in this class:

- ☐ None
- ☐ First of the month following Date of Hire
- ☐ First of the month following one month (30 days) from Date of Hire
- ☐ First of the month following two months (60 days) from Date of Hire
- ☐ 30 days from Date of Hire
- ☐ 60 days from Date of Hire
- ☐ 90 days from Date of Hire

Choose the employer medical premium contribution amount for each month for employees:

_____ % or $

Note: Employers must contribute at least 50% of the employee premium.

Choose the employer medical premium contribution amount for each month for employees' dependents:

_____ % or $ ☐ No contribution

Note: This section should only be filled out if you would like to contribute a different amount towards employee's dependents. Use same contribution type (% or $).

Section C.2: Plan Selections - All plans include pediatric dental coverage.

Select up to 3 plans to offer this class (visit hioscar.com/forms for full plan details):

- ☐ LCP Bronze $7500
- ☐ LCP Bronze $7500 HSA
- ☐ LCP Gold $1250
- ☐ LCP Gold $1800
- ☐ LCP Gold $2750
- ☐ LCP Silver $0
- ☐ LCP Silver $2750
- ☐ LCP Silver $3250 HSA
- ☐ LCP Silver $3400
- ☐ LCP Silver $3900
- ☐ LCP Silver $5000
- ☐ LCP Platinum $300
- ☐ LCP Platinum 750

- ☐ OAP Bronze $7500 HSA
- ☐ OAP Bronze $7500
- ☐ OAP Gold $1250
- ☐ OAP Gold $1800
- ☐ OAP Gold $2750
- ☐ OAP Silver $0
- ☐ OAP Silver $2750
- ☐ OAP Silver $3250 HSA
- ☐ OAP Silver $3400
- ☐ OAP Silver $3900
- ☐ OAP Silver $5000
- ☐ OAP Platinum $300
- ☐ OAP Platinum $750

Deductibles and out-of-pocket accumulation period are on a... ☐ Calendar year ☐ Contract year basis

Would you like premiums to be composite rated or age-rated? ☐ Composite Rated ☐ Age Rated

Do you wish to offer coverage for Domestic Partners? ☐ No ☐ Yes

Insured by Cigna Health and Life Insurance Company.

Insurance benefits administered by Oscar Management, a third party administrator. Cigna insurance coverage contains exclusions and limitations. For complete details on product availability and coverage, please refer to your plan documents or member ID card.

Section D: General agreement

Please read this section carefully before signing the application:

We apply to obtain the coverage designated herein. To the best of our knowledge and belief, all information on this application is true and complete, and Cigna Administered by Oscar may rely on this application in deciding whether to provide coverage. If the application is not complete, Cigna Administered by Oscar reserves the right to reject it and notify us in writing. We understand and agree that no coverage will be effective before the date determined, and that such coverage will be effective only if we have paid our first month's premium and this application is accepted. We further understand and agree that we should keep prior coverage in force until notified of acceptance in writing and that no agent has the right to accept this application or bind coverage. If this application is accepted, it becomes a part of our contract with Cigna Administered by Oscar.

The Brokers named on this application are hereby authorized to process any enrollment transactions for the company's coverage upon direction from the authorized group representative (including, but not limited to, member enrollment, member terminations, member address changes, group contact changes, group address changes, plan renewal changes, and group contract terminations). This authorization shall be effective immediately and we agree that the company will be bound by the actions performed by the herein-named Broker pursuant to the signature below. Additionally, we acknowledge that we must notify Cigna Administered by Oscar in writing to void this agreement in the event of a change in the company's Broker of Record.

Business administrator signature Sign here x.....	Printed name and title	Date (mm/dd/yyyy)
Accepted by Cigna Administered by Oscar authorized representative	Printed name	Date (mm/dd/yyyy)

I am authorized to sign on the company represented in this surveys behalf

Yes ☐

No ☐