oscar

New Jersey
Application for Small Group Health Benefits Policy

Instructions

The attached forms should be completed with the assistance of your authorized Broker or Oscar Sales Representative. Please complete all necessary forms in their entirety. Please print in ink or type your responses.

Ensure that all areas requiring a signature and date are complete. The Officer, Partner, Owner and / or Correspondent signing the application must be listed on the New Jersey Small Employer Certification. Completed enrollment application forms should be entered on the Oscar enrollment portal (business.hioscar.com) prior to your effective date. This can be completed by your Broker or an Oscar Sales Representative.

Required documents

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

New Jersey Application for Small Group Health Benefits Policy
This can be completed online in the Oscar enrollment portal and Section 5 (Signature) should be signed, scanned, and uploaded where indicated in the portal.

New Jersey Small Employer certification
This entire form is required to be signed, scanned, and uploaded to the portal

New Jersey Employee Enrollment application
One application should be completed for each employee or COBRA/continuation of benefits recipient enrolling. These applications can be completed entirely online by the employees, or completed on paper and data entered into the online portal.

Small Employer Health Benefits Waiver of Coverage
One form is needed for each employee waiving or refusing coverage. These can be completed online.

Payroll verification through appropriate tax documentation, i.e., WR30
WR30 is required for groups, unless there are seven (7) or more eligible employees enrolling. If WR30 is not available a substitute payroll document such as a K-1, Schedule C and/or 1120 will suffice. All payroll verifications must be scanned and uploaded to the portal.

Premium payment
Payment of the first month's premium must be submitted with the application either by 1) ACH payment or 2) Check. ACH payments can be setup for automatic deduction on the first of every month or can be uploaded solely for an automatic first payment. ACH form can be found at https://www.hioscar.com/brokers/forms/small-group. If the group wishes to pay the first premium via check they must mail it to the address below with the Group Name and Group Number, if available.

Oscar Garden State Insurance Corporation
P.O. Box 419895
Boston, MA 02241 - 9895

oscar

New Jersey
Application for Small Group Health Benefits Policy

Preferred effective date of coverage (mm/dd/yyyy)? Must be the 1st or 15th of a future month. (Note: The Effective Date will be on or after the date Oscar approves the application.)	Policy Number: __________ (Oscar Use Only) New policy Change in policy

Section 1: Policyholder information

Policy holder (full legal name of company)	Employer Tax ID	
Main address		
City	State	ZIP
Mailing address (if different than address from above)		
City	State	ZIP
Telephone	Facsimile	Email address
Contract information should be provided (check one) Electronically ☐ Hard copy		
Correspondent	Title	
Type of organization Corporation Partnership Proprietorship Other (explain):		
Nature of business (specify):	SIC code	
Number of full-time employees in your company*	Number of full-time employees to be insured	Class or classes to be excluded

Insurance requested for

Employees Only Employees and Dependents including Spouse Employees and Dependents excluding Spouse

→ Should the plan provide coverage for domestic partners as permitted by P.L. 2003, c. 246? Yes No
If yes, should the plan provide coverage for coverage of children of a covered domestic partner? Yes No

Is the employer subject to the requirements of COBRA? Yes No

Is the employer subject to the requirements of Medicare as Secondary Payor Rules for eligibility due to age? Yes No
Due to disability? Yes No

Orientation period? Yes No

*Refer to the New Jersey Small Employer Certification for the definition of a full-time employee.

Waiting period before employees become insured (may not exceed 90 days):				
Present employees	No waiting period	One month	Two months	90 days
New or rehired employees	No waiting period	One month	Two months	90 days

Period for Annual Employee Open Enrollment Period

What percentage of the premium will the employer pay?	Deposit ($)

Premium paid* — Monthly — Automatic checking withdrawal

Affiliates, subsidiaries or branches (Must be included for purposes of participation)

Legal name & location	No. of full-time employees in this company	No. of full-time employees to be insured

Section 2: Specifications for coverage

Please select up to 3 desired health benefits options:

- Oscar Bronze $3,000
- Oscar Silver $0
- Oscar Silver $1,500
- Oscar Silver $2,500
- Oscar Silver $2,500 PPO
- Oscar Gold $1000
- Oscar Platinum $0

*All plans include pediatric dental.

Deductibles and out-of-pocket accumulation periods are on a... — Calendar year — Contract year basis

Section 3: All questions must be answered

1. Is there any Group Health Plan:
   Now in force and to be continued? — Yes — No
   Currently being applied for? — Yes — No

If "Yes", identify the name of the Group Health Plan, give a description of the plan(s) and name of insurance carrier(s):

2. Name of present or prior group carrier (required)

Effective date of prior coverage	Cancellation/termination date

Is the coverage applied for in this application replacing other group insurance? — Yes — No

If "Yes", give reason:

Plan being replaced:

3. Are extended benefits provided in case of termination of health benefits? — Yes — No

*Premium will be due as of the effective date. The premium for the first month of coverage must be attached.

To the best of your knowledge are there any current or former employees or their eligible dependents whose health insurance is being continued?	Yes	No

Please provide the following information for each current/former employee or dependent on health continuations.

Name of employee / dependent	Date of birth	Type of continuation State/Federal/Extended Benefits	Reason for termination Disability/Other	Continuation dates Start	End

(If additional space is needed, attach a separate sheet, signed and dated.)

To the best of your knowledge:		
Are any employees or dependents presently incapacitated?	Yes	No
Are any dependent children incapable of self-support due to a physical or mental disability?	Yes	No

Additional space to explain if items in this section were answered "Yes".
Give details including names where appropriate.

Does the employer participate in an arrangement with a Professional Employer Organization? (Refer to Advisory Bulletin 00-SEH-02 if you need information concerning what constitutes a Professional Employer Organization.)	Yes	No
If yes, is health coverage available as a client of the PEO?	Yes	No

Section 4: Agent/producer information and underwriting group enrollment use

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 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 Oscar reviews and approves the application and the employer receives a written notice from Oscar.
5. I am the appointed agent/broker and am receiving commissions for the submission of this client. No portion of my commission payments from Oscar shall be paid to an agent/broker/producer not appointed/approved by Oscar.
6. I have advised the client not to terminate any existing coverage until receiving written notification from 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
Oscar broker ID		Oscar 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)

General agent/producer/broker use only

General agency name

General agency representatives

General agency representative name	Email

Section 5: Signature

It is understood that, except as provided under applicable regulations, no individual shall become insured while not actively at work on a full-time basis, and only full-time employees are eligible. (Refer to the definition on the New Jersey Employer Certification.) It is further understood that no agent has power on behalf of Oscar to make or modify any request or application for insurance or to bind Oscar by making any promise or representation or by giving or receiving any information.

It is further understood that no insurance will be effective unless and until the application is accepted in writing by Oscar. Final rates will be based on enrollment data as of the Policy effective date. No contract of insurance is to be implied in any way on the basis of the completion and/or submission of this application.

It is understood that I am responsible to provide Oscar with timely and accurate information regarding the date of hire for new employees and that the requested effective date of coverage will properly apply any orientation period and waiting period requirements applicable to my plan. It is further understood that any retroactive termination requests must be limited to those for which no premium or contribution has been paid for the termination period by the employee or dependent whose coverage is to be retroactively terminated.

☐ Please read this statement and check to confirm. I confirm that I have received the Summary of Benefits and Coverage (SBC) documents associated with the plan or plans I selected on this application. I confirm I will provide SBCs to plan participants and beneficiaries as required by federal regulations and guidance related to the distribution of the SBC, including the requiring for timing and delivery.

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Dated at: ________________ on __________________

Signature of employer	Print name of Officer, Partner or Proprietor
Witness to Signature (Sign here) x	Signature of Officer, Partner or Proprietor (Sign here) x ....

Note: If there are any modifications to the statements and answers given in this application (i.e., crossed out, whited-out, erased information), the applicant must attest to the modifications by giving a complete signature in the margin near the modification.

Notice of Non-Discrimination:

Discrimination is Against the Law

Oscar complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. Coverage for medically necessary health services is made available on the same terms for all individuals, regardless of sex assigned at birth, gender identity, or recorded gender. Oscar will not deny or limit coverage to any health service based on the fact that an individual's sex assigned at birth, gender identity, or recorded gender is different from the one to which such health service is ordinarily available. Oscar will not deny or limit coverage for a specific health service related to gender transition if such denial or limitation results in discriminating against a transgender individual.

Oscar:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services at all times to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Member Services at 1-855-OSCAR-55 (TTY: 7-1-1).

If you believe that Oscar has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

CA Members: Oscar Health Plan of California, Attention Grievances 9942 Culver City Blvd., PO Box 1279, Culver City, CA 90232

All other Members: Oscar Insurance, Attention: Grievances, PO Box 52146, Phoenix, AZ 85072

1-855-OSCAR-55 (TTY: 7-1-1), Mon - Fri 8 am - 8 pm/ Sat - Sun 9 am - 5 pm (EST), Fax: 1-888-977-2062, Email: help@hioscar.com. You can file a grievance in person or by mail, fax, or em ail. If you need help filing a grievance, Oscar's Grievances Department is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW Room 509F,
HHH Building Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Language Assistance Services for the Deaf or Hard of Hearing
ATTENTION: If you are deaf or hard of hearing, talk to text services, free of charge, are available to you. Call 1-855-Oscar-55 and dial 711 to receive TTY/TDD services.

Español (Spanish): ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-OSCAR-55.

繁體中文 (Chinese): 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-OSCAR-55.

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1–855–OSCAR–55.

Kreyòl Ayisyen (French Creole): ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-855-OSCAR-55.

한국어 (Korean): 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-OSCAR-55 번으로 전화해 주십시오.

Italiano (Italian): ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-OSCAR-55.

אידיש (Yiddish): אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט 1-855-OSCAR-55.

বাংলা (Bengali): লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১ -855-OSCAR-55.

Polski (Polish): UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-855-OSCAR-55.

العربية (Arabic): ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1–855–OSCAR–55.

Français (French): ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-OSCAR-55.

اُردُو (Urdu): خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 1-855-OSCAR-55

Tagalog (Tagalog – Filipino): PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-OSCAR-55.

λληνικά (Greek): ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-855-OSCAR-55.

Shqip (Albanian): KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-855-OSCAR-55.

Tiếng Việt (Vietnamese): CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-OSCAR-55.

हिंदी (Hindi): ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-855-OSCAR-55 पर कॉल करें।

فارسی (Farsi): توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما .بگیرید ت 1-855–OSCAR-55.

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-OSCAR-55.

ગુજરાતી (Gujarati): સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-855-OSCAR-55.

日本語 (Japanese): 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-855-OSCAR-55 まで、お電話にてご連絡ください。

ພາສາລາວ **(Lao):** ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-855-OSCAR-55.

Português (Portuguese): ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-855-OSCAR-55.

አማርኛ (Amharic): ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-855-OSCAR-55.

Հայերեն **(Armenian):** ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-855-OSCAR-55.

ਪੰਜਾਬੀ (Punjabi): ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-855-OSCAR-55 'ਤੇ ਕਾਲ ਕਰੋ।

ខ្មែរ **(Cambodian):** ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-855-OSCAR-55.

Hmoob (Hmong): LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-855-OSCAR-55.

ภาษาไทย (Thai): ถ้ าคุณพูดภาษาไทยคุณสามารถใช้ บริการช่ วยเหลือทางภาษาได้ ฟรี โทร 1-855-OSCAR-55.

Deitsch (Pennsylvania Dutch: Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1–855–OSCAR–55 (TTY: 711).

Oroomiffa (Oromo): XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-855-OSCAR-55.

Nederlands (Dutch): AANDACHT: Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel 1-855-OSCAR-55.

Українська (Ukrainian): УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-855-OSCAR-55.

Română (Romanian): ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-855-OSCAR-55

Navajo Diné Bizaad: Díí baa akó nínízin: Díí saad bee yáníłti'go **Diné Bizaad**, saad bee áká'ánída'áwo'dę́ę́', t'áá jiik'eh, éí ná hólǫ́, kojį' hódíílnih 1-855-OSCAR-55 (TTY:711.)

Srpsko-hrvatski (Serbo-Croatian): OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-855-OSCAR-55