oscar

Employee Enrollment Application / Change Request Form - California 2021

Instructions: You (the employee) must complete this application. You are solely responsible for its accuracy and completeness. To avoid the possibility of delay, answer all questions and be sure to sign and date your application. Please complete this form in blue or black ink and submit to your employer when complete.

Section A: Employer information

Employer name	Employer group ID (ex: BIZ12345678 – if unavailable, leave blank)

Employee's status (check all options that apply):

- ☐ Active
- ☐ Union
- ☐ Non-union
- ☐ Hourly
- ☐ Salary
- ☐ Other (please explain):

Hours worked by employee per week	Date of hire (mm/dd/yyyy)

Section B: Application type

Application type

- ☐ New application
- ☐ Change benefits plan
- ☐ Information update (name, address, etc.)
- ☐ Add/remove a dependent
- ☐ Termination

Application reason

- ☐ Open enrollment
- ☐ New hire
- ☐ Rehire
- ☐ COBRA
- ☐ Cal-COBRA
- ☐ Qualifying Life Event
- ☐ Other (please explain):

If you selected **COBRA** or **Cal-COBRA** as the application reason above, please select one of the following qualifying events:

- ☐ Left employment
- ☐ Reduction in hours
- ☐ Death
- ☐ Divorce or legal separation
- ☐ Loss of dependent child status
- ☐ Medicare entitlement
- ☐ Exhauted COBRA (Cal-COBRA applicants only)

Continuation qualifying event date (mm/dd/yyyy):

If you selected **Qualifying Life Event** as the application reason above, please select one of the following applicable qualifying life events and its date*:

- ☐ Loss of coverage
- ☐ Marriage
- ☐ Birth
- ☐ Adoption
- ☐ Court-ordered dependent addition
- ☐ Moved to service area
- ☐ Other (please specify):

Qualifying event date (mm/dd/yyyy):

* Note that appropriate documentation must be submitted along with this form to be eligible for coverage.

Section C: Member information

Instructions: The below information must be completed for the subscriber and any additional family members to be covered. An eligible dependent may be your spouse, domestic partner, your children, your spouse's children or your domestic partner's children.

Coverage of a child dependent will continue to the end of the month in which the child turns age 26 unless he or she qualifies as a disabled person (if you have a disabled dependent, please call us at (855) 672-2784 to request a disabled dependent form, or visit hioscar.com/forms).

If you would like to add additional dependents, please print another copy of this page and attach it to your application.

	Employee	Spouse	Child	Child 2
First name				
Middle initial				
Last name				
Social Security Number or TIN	– – ☐ No SSN	– – ☐ No SSN	– – ☐ No SSN	– – ☐ No SSN
Sex	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
Date of birth (mm/dd/yyyy)				
Preferred language (optional)				
Check all that apply		☐ Domestic partner ☐ Employee of this business	☐ Disabled ☐ Employee of this business	☐ Disabled ☐ Employee of this business
For the section below, if all members share the same details - only fill out the first column. However, if there are differences, fill out the other respective columns. Please note: PO Boxes do not count as a valid address.				
Residential address, line 1				
Residential address, line 2				
City and state				
ZIP code				
County				
Email				
Phone (xxx) xxx - xxxx				

On the day your coverage begins, if you or any of your family members will be eligible or covered by Medicare or other coverage fill out the section below.

Eligible for Medicare?	☐ No ☐ Yes If yes, why? ☐ Age ☐ Disability ☐ ESRD Onset date: / /	☐ No ☐ Yes If yes, why? ☐ Age ☐ Disability ☐ ESRD Onset date: / /	☐ No ☐ Yes If yes, why? ☐ Age ☐ Disability ☐ ESRD Onset date: / /	☐ No ☐ Yes If yes, why? ☐ Age ☐ Disability ☐ ESRD Onset date: / /
Medicare coverage Check appropriate box and list effective date (mm/dd/yyy) and Medicare ID number	☐ Part A: / / ☐ Part B: / / ☐ Part C: / / ☐ Part D: / / ID number:	☐ Part A: / / ☐ Part B: / / ☐ Part C: / / ☐ Part D: / / ID number:	☐ Part A: / / ☐ Part B: / / ☐ Part C: / / ☐ Part D: / / ID number:	☐ Part A: / / ☐ Part B: / / ☐ Part C: / / ☐ Part D: / / ID number:
Other health coverage Check appropriate box and list coverage dates (mm/dd/yyyy), carrier name and Policy number	☐ Individual ☐ Group Start date: / / End date: / / Carrier name: Policy number:	☐ Individual ☐ Group Start date: / / End date: / / Carrier name: Policy number:	☐ Individual ☐ Group Start date: / / End date: / / Carrier name: Policy number:	☐ Individual ☐ Group Start date: / / End date: / / Carrier name: Policy number:

Section D: Choose your plan

Not all plans listed may be available - check with your employer for more details.

- ☐ Oscar Bronze $8,550 EPO Option 1
- ☐ Oscar Bronze $8,550 EPO Option 2
- ☐ Oscar Bronze 60 HDHP EPO $7,000/0% + Child Dental
- ☐ Oscar Bronze 60 EPO $6,300/$65 + Child Dental

- ☐ Oscar Silver $0 EPO
- ☐ Oscar Silver $2,000 EPO
- ☐ Oscar Silver 70 EPO $1,550/$50+ Child Dental Oscar
- ☐ Oscar Silver 70 EPO $2,250/$55+ Child Dental Oscar
- ☐ Silver 70 HDHP EPO $2,500/20% + Child Dental

- ☐ Oscar Gold $500 EPO
- ☐ Oscar Gold $1,000 EPO
- ☐ Oscar Gold $2,000 EPO
- ☐ Oscar Gold 80 EPO $0/$30 + Child Dental
- ☐ Oscar Gold 80 EPO $250/$35 + Child Dental

- ☐ Oscar Platinum $0 EPO Option 1
- ☐ Oscar Platinum $0 EPO Option 2
- ☐ Oscar Platinum 90 EPO $0/$20 + Child Dental

Section E: Terms, conditions, and authorizations

Please read this section carefully before signing the application:

Eligible Employee means:
An active employee of the Employer who works the number of hours per week to be eligible for benefits as defined by the Employer, who meets the definition of "employee" under California State and Federal laws, and approved by Oscar Health Plan of California ("Oscar") as of the effective date. Employment must be verifiable from state or federal wage tax reports;
• An employee, as defined above, who enters into employment after the coverage effective date and who completes the group imposed waiting period for eligibility (if any) and applies for coverage within 30 days;
• Any other class of persons identified by the Employer, provided that written approval of their eligibility is obtained from the Company(ies); or
• An employee, who is eligible for continued coverage under California State or Federal laws.

Eligible Dependent means:
• Your spouse, domestic partner, or child age 26 or younger, including a newborn, natural child, or a child placed with you for adoption, a stepchild or any other child for whom you have legal guardianship or court ordered custody. Coverage for children will end on the last day of the month in which the children reach age 26.
• An unmarried child (at any age during initial or continued enrollment), who is incapable of self-sustaining employment by reason of physically or mentally disabling injury, illness, or condition; and is chiefly dependent upon the Subscriber for support and maintenance.
• Dependents eligible for continued coverage under California State or Federal laws.

In signing this, I represent that:
• I am an Eligible Employee (as defined above), and I am requesting coverage for myself and all Eligible Dependents (as defined above) listed and authorize my Employer to deduct any required contributions for this insurance from my earnings.
• I understand all benefits are subject to conditions stated in the Group Policy.
• I have read or have had read to me the completed application, and I realize any false statement or misrepresentation in the application may result in loss of coverage.

Applicant signature	Printed name	Date (mm/dd/yyyy)
Sign here X		

Note: Oscar reserves the right to collect and review supporting documentation.