Nongroup Enrollment/Change Request Florida Off-Exchange

Choose your plan

[ ] Oscar Bronze Classic
[ ] Oscar Bronze Classic Next
[ ] Oscar Bronze Classic Next 2
[ ] Oscar Bronze HDHP
[ ] Oscar Bronze Simple
[ ] Oscar Silver - $1,500 Ded
[ ] Oscar Silver Classic
[ ] Oscar Silver Classic - $0 Ded
[ ] Oscar Silver Classic Copay
[ ] Oscar Silver Classic Next
[ ] Oscar Silver HDHP
[ ] Oscar Silver Saver
[ ] Oscar Silver Saver 2
[ ] Oscar Silver Virtual Care
[ ] Oscar Gold Classic
[ ] Oscar Secure

Note: Pediatric Dental coverage is included in all medical plans

Oscar ID (if changing an existing plan)

Who are you buying insurance for?

[ ] Individual
[ ] Individual & Spouse
[ ] Parent & Child(ren)
[ ] Family
[ ] Child Only

Type of Activity

[ ] Add dependent
[ ] Remove dependent
[ ] Change benefit plan
[ ] Marital status change
[ ] Update name and/or address
[ ] New enrollment

Special enrollment period (following a triggering event, see list in instructions)

Requested Start Date ____/____/_____

Date of QLE ____/____/_____

Qualifying life event (if applicable)

Who's Covered

	Name (First, Middle Initial, Last)	Is dependent disabled?*	Sex (M/F)	Social Security No.	Date of Birth (MM/DD/YYYY)	Phone number	Email	Eligible for Medicare?	Smoker?**
Applicant									
Spouse									
Child dependent(s)									

* If you have a disabled dependent over age 26, please contact us at brokers@hioscar.com to request a disabled dependent form
** Within the past 6 months have you used any tobacco products 4 or more times per week, on average, excluding religious or ceremonial use? Tobacco products include products such as cigarettes, e-cigarettes, cigars, chewing tobacco, snuff, pipe tobacco, and others. Note that when determining your premium, Oscar may consider whether you smoke or use tobacco. Answer required for ages 19+.

Just a few more questions

Home address (P.O. box does not qualify) | Apt # | City | County | State | Zip code

Home phone | Cell phone | Email address

Primary language (if other than English) | Marital status Single Married Domestic Partner

If your mailing address is different than your home address, please enter it below

Name | Address | Apt # | City | County | State | Zip code

Do you maintain a home in another state or county? Yes No

Have you ever tested positive for exposure to HIV or been diagnosed as having ARC or AIDS? Yes No

GA / Broker info (if applicable)

	Name	National Producer Number (NPN)	Agency name	Phone	Email	Florida License Identification Number
GA						
Broker						
Co-broker						

Please Read the Following Terms & Conditions Carefully

I understand that upon review of my Contract that I may cancel it. Any request to cancel must be made in writing within 14 days from the date I receive the Contract. On behalf of myself and any covered dependents, to the extent permitted by law, I hereby authorize all health care providers who have rendered service to any of us and any payers of claims to provide to Oscar any records pertaining to care provided, claims paid and/or our medical history. I authorize Oscar to provide such information to network physicians for the purpose of continuity of care, medical management, etc. Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree. I am applying for coverage for myself, my spouse and my eligible dependent children named on this application. All statements made within this form are true and accurate to the best of my knowledge.

_____ ____/____/_____

Signature Date

By typing your name, you are signing this Agreement electronically and consenting to its terms & conditions. You agree your electronic signature is the legal equivalent of your manual signature on this Agreement. Note that Oscar will use either your qualifying event date or date the application was submitted to Oscar to determine your effective date of coverage. We will not use the signature date on this application.

Instructions

- With the exception of the last question, you must complete all sections, and sign and date this form.
- Please print except when a signature is requested.
- If a dependent child is disabled and you want to continue his or her coverage beyond age 26, attach proof of disability and contact Oscar for a Disabled Dependent form.
- If you are applying to add a spouse, civil union partner, domestic partner, or child outside of Open Enrollment please check “Add dependent” in the “Type of Activity” section and identify the applicable Qualifying Life Event.
- Eligible for Medicare means the person satisfies the requirements for Medicare but has not yet enrolled in Medicare. Entitled or Enrolled under Medicare parts A or B means you have Medicare and CANNOT enroll in an individual plan.
- If you have any questions concerning the benefits or services provided by or excluded under this policy, contact a customer service representative by navigating to “Get help” on hioscar.com or emailing help@hioscar.com before signing this form.
- Keep a copy of this completed application!
- You can print out a temporary ID card on hioscar.com if needed. Coverage must be verified with Oscar prior to visiting with a specialist or admission to a hospital.

Qualifying Life Events include, but are not limited to:

1. Involuntary loss of minimum essential coverage
2. Dependent attained age 26 and lost coverage
3. Marketplace changed your subsidy determination
4. Change in household due to marriage, domestic partnership, birth, adoption or placement for adoption, placement in foster care or a child support order or other court order
5. Gained access to plans as a result of permanent move to a new state
6. No longer incarcerated
7. Became lawfully present
8. Holds or gained status as an Native American or Alaska Native

For a list of Qualifying Life Event documentation, please see hioscar.com/brokers

Eligibility

- You must not be enrolled in or entitled to Medicare Parts A or B.
- If application is made for the Secure Plan the following additional requirements apply:
  1. You must be under 30 years old at the beginning of the plan year; OR
  2. You must have a Certificate of Hardship Exemption from the Marketplace. Attach a copy to your application.
- The Annual Open Enrollment Period is the designated period of time each year during which you may apply for, or change coverage for, yourself and your dependents. Your application must be received during the designated Annual Open Enrollment Period, unless you’ve experienced a Qualifying Life Event. For 2021 coverage, the Annual Open Enrollment Period runs from November 1st, 2020 through December 15th, 2020.
- A Special Enrollment Period lasts for 60 days following a Qualifying Life Event. In certain cases, the applicant may also apply during the 60 days leading up to the Qualifying Life Event.
- Pediatric dental is a mandatory Essential Health Benefit under the Affordable Care Act (ACA) and is included in all plans. Benefits are provided to any covered person under the age of 19.
- Note: If you currently have coverage, and the plan for which you are applying will replace the current coverage, you should not terminate your current policy until the new coverage is active.

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