oscar

New York 2021 Employee Enrollment Application/Change Request

Instructions: With the exception of Section A, 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: Information provided by your employer (to be completed by the employer)

Employer name	Employer group ID (ex: BIZ12345678)	
Employee's work address		
City	State	ZIP code
Employee's status (check all options that apply):	☐ Active ☐ Union ☐ Non-union ☐ Hourly ☐ Salary ☐ Other (please explain):	
Employee's class	Date of hire (mm/dd/yyyy)	Hours worked per week

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 ☐ New York State Continuation ☐ Qualifying Life Event
☐ Other (please explain):

If you selected **COBRA** or **New York State Continuation** as the application reason above, please select one of the following qualifying life events:

☐ Left employment
☐ Death
☐ Divorce or legal separation
☐ Loss of dependent child status
☐ Medicare entitlement
☐ Reduction in hours

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:

☐ Loss of coverage*
☐ Marriage
☐ Birth
☐ Adoption*
☐ Court-ordered dependent addition*
☐ Moved to service area*

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

* indicates 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 (if this option is chosen by your employer), your children, your spouse's children or your domestic partner's children (if applicable). *Please attach a copy of the form below to account for more than two children.*

Coverage of a child dependent will continue to the end of the calendar 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).
- Your employer has chosen extended dependent coverage for adult dependents through age 29 and your dependent qualifies.
- Your dependent qualifies for and enrolls in the Young Adult Option, which extends coverage for young adults through age 29.

	Employee	Spouse	Child	Child 2
Full name				
Social security number	☐ Not available	☐ Not available	☐ Not available	☐ Not available
Check all that apply:		☐ Domestic partner ☐ Employee of this business	☐ Disabled ☐ Young adult ☐ Employee of this business	☐ Disabled ☐ Young adult ☐ Employee of this business
Gender	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
Date of birth (mm/dd/yyyy)				
For the section below, if all members share the same details - only fill out the first column. However, if there are differences or if a dependent is enrolling as a Young Adult, please fill out the other respective columns.				
Address line 1				
Address line 2 (optional)				
City				
State				
ZIP code				
County				
Phone (xxx) xxx - xxxx				
Email				
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	☐ Yes ☐ No If yes, why? ☐ Age ☐ Disability ☐ ESRD Onset date:	☐ Yes ☐ No If yes, why? ☐ Age ☐ Disability ☐ ESRD Onset date:	☐ Yes ☐ No If yes, why? ☐ Age ☐ Disability ☐ ESRD Onset date:	☐ Yes ☐ No If yes, why? ☐ Age ☐ Disability ☐ ESRD Onset date:

Medicare coverage (check appropriate box and list effective date 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, 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

Only a selection of these plans have been selected as options by your employer - check with them for details.

All plans below include pediatric dental coverage.

- ☐ Circle Platinum $0 Option 1
- ☐ Circle Platinum $0 Option 2
- ☐ Circle Gold $0
- ☐ Circle Gold $1000
- ☐ Circle Gold $1250
- ☐ Circle Gold $2000
- ☐ Circle Silver $0
- ☐ Circle Silver $3000
- ☐ Circle Silver $3250
- ☐ HSA Circle Silver $5000
- ☐ Circle Bronze $4500
- ☐ Circle Bronze $5400 HSA
- ☐ Circle Bronze $7300

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 New York State and Federal laws, and approved by 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 New York State or Federal laws.

Eligible Dependent means:
Your spouse, 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. The age limit for coverage of a child is (1) age 26 unless the Employer has chosen extended dependent coverage and the dependent qualifies, or (2) You or the dependent have purchased a rider to extend coverage for young adults through age 29 and Your dependent is eligible. Coverage for children will end on the last day of the month in which the children reach age 26, or age 30 if applicable.

An unmarried child (at any age during initial or continued enrollment), who is incapable of self-sustaining employment because of mental retardation, mental illness, developmental disability, or physical incapacity that began prior to the child reaching the age limit for coverage. Coverage may be obtained for the child who is beyond the age limit at the initial enrollment if You provide proof of handicap and dependence at the time of enrollment. You may be asked to provide a physician's certification (HAC 506) of the dependent's condition.

W-9 Certification:
As part of the W-9 Certification required by the Internal Revenue Service (IRS), I certify that the Social Security number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me) and I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the IRS that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding and I am a U.S. citizen or other U.S. person.

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 Contract and coverage documents.

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.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

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