oscar | business

# New York
# Employee Enrollment Application/ Change Request

**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: Information Provided by Your Employer (to be completed by the *employer*)

| Employer Name | | Employer Group No. | |
|---|---|---|---|
| Employer Address (Not P.O. Box) | | | |
| City | State | Zip Code | County |
| Employment Status ☐ Full Time ☐ Part Time | Employee ID | Date of Hire (mo/day/yr) | Hours Worked Per Week |

## Section B: Application Type

Application type

☐ New Applicant ☐ Update Name or Address ☐ Add/Remove Dependent

☐ Change Benefits Plan ☐ Termination

Application reason

☐ New Hire ☐ Open Enrollment ☐ Rehire ☐ Young Adult Option (qualified dependents only)

☐ COBRA/State Continuation ☐ Qualifying Life Event ☐ Other: _____

If you selected COBRA/State Continuation above, please select the applicable reason:

- ☐ Left employment
- ☐ Reduction in hours
- ☐ Death
- ☐ Divorce or legal separation
- ☐ Loss of dependent child status
- ☐ Covered by employee's Medicare entitlement

COBRA qualifying event date:
_____ (mo/day/yr)

If you selected Qualifying Life Event above, please select the applicable qualifying life event:

- ☐ Loss of coverage
- ☐ Marriage
- ☐ Birth or adoption
- ☐ COBRA/State Continuation exhausted
- ☐ Divorce or legal separation
- ☐ Death
- ☐ Loss of Medicaid eligibility

Other qualifying event date:
_____ (mo/day/yr)

## Section C: Employee Information

| First Name | M.I. | Last Name | |
|---|---|---|---|
| Social Security No. (If you don't have one, write N/A) | | Gender ☐ Male ☐ Female | Date of Birth (mo/day/yr) |

## Section C: Employee Information (continued)

| | | | |
|---|---|---|---|
| Home Address Line 1 | | Home Address Line 2 | |
| City | State | Zip Code | County |
| Mailing Address Line 1 (if different from above) | | Mailing Address Line 2 | |
| City | State | Zip Code | County |
| Preferred Phone | | Preferred Email | |

## Section D: Spouse and Dependent Information

**Instructions**: The below information must be completed for 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). 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 1-855-672-2784 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.

Are you required to provide coverage for any minor dependent as the result of a court decree? ☐ No ☐ Yes

## Section D.1: Spouse/Domestic Partner Information

| | | | |
|---|---|---|---|
| Would you like to cover your spouse/domestic partner? ☐ No ☐ Yes | | Relationship to applicant: ☐ Spouse ☐ Domestic Partner | |
| First Name | M.I. | Last Name | |
| Social Security No. | | Gender ☐ Male ☐ Female | Date of Birth (mo/day/yr) |

## Section D.2: Dependent Information (complete for each dependent you would like to add to your coverage)

| | | | |
|---|---|---|---|
| First Name | M.I. | Last Name | |
| Social Security No. | | Gender ☐ Male ☐ Female | Date of Birth (mo/day/yr) |
| | | | |
| First Name | M.I. | Last Name | |
| Social Security No. | | Gender ☐ Male ☐ Female | Date of Birth (mo/day/yr) |
| | | | |
| First Name | M.I. | Last Name | |
| Social Security No. | | Gender ☐ Male ☐ Female | Date of Birth (mo/day/yr) |

*If you have more than three dependents, please fill out an additional page 2 (Section D. 2) of an enrollment form and attach it to your application.*

## Section E: Other Coverage

Are you or is anyone applying for coverage currently eligible for Medicare? ☐ No ☐ Yes

If yes, please complete the following for each eligible person:

Name: _____ Reason: ☐ Age ☐ Disability ☐ ESRD Onset Date: _____

If ESRD, are you within your 30 month coordination period? ☐ No ☐ Yes

Name: _____ Reason: ☐ Age ☐ Disability ☐ ESRD Onset Date: _____

If ESRD, are you within your 30 month coordination period? ☐ No ☐ Yes

Name: _____ Reason: ☐ Age ☐ Disability ☐ ESRD Onset Date: _____

If ESRD, are you within your 30 month coordination period? ☐ No ☐ Yes

On the day your coverage begins, will you or a family member be covered by Medicare or other health coverage? ☐ No ☐ Yes

If yes, please complete the section below:

| | Employer/Subscriber | Spouse | Child | Child |
|---|---|---|---|---|
| Name of Person Covered | | | | |
| Medicare Coverage (check appropriate box and list effective date and Medicare ID Number) | ☐ Part A ( / / )<br>☐ Part B ( / / )<br>☐ Part C ( / / )<br>☐ Part D ( / / )<br>ID No: | ☐ Part A ( / / )<br>☐ Part B ( / / )<br>☐ Part C ( / / )<br>☐ Part D ( / / )<br>ID No: | ☐ Part A ( / / )<br>☐ Part B ( / / )<br>☐ Part C ( / / )<br>☐ Part D ( / / )<br>ID No: | ☐ Part A ( / / )<br>☐ Part B ( / / )<br>☐ Part C ( / / )<br>☐ Part D ( / / )<br>ID No: |
| Medical Coverage (check appropriate box and list coverage dates, carrier name and Policy Number) | ☐ Individual<br>☐ Group<br>Start Date: ( / / )<br>End Date: ( / / )<br>Carrier Name:<br>Policy No: | ☐ Individual<br>☐ Group<br>Start Date: ( / / )<br>End Date: ( / / )<br>Carrier Name:<br>Policy No: | ☐ Individual<br>☐ Group<br>Start Date: ( / / )<br>End Date: ( / / )<br>Carrier Name:<br>Policy No: | ☐ Individual<br>☐ Group<br>Start Date: ( / / )<br>End Date: ( / / )<br>Carrier Name:<br>Policy No: |

*Note: If you need additional space, please reprint this page and attach it to your form.*

## Section F: Choose Your Plan

☐ Market Platinum
☐ Market Gold
☐ Market Silver
☐ Market Bronze

☐ Simple Platinum
☐ Simple Gold
☐ Simple Silver
☐ Simple Bronze

*Note: Not all plans may be available*

## Section G: 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. In the case of (1) or (2), the dependent age limit for coverage is age 30. 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 cannot support himself or herself because of mental retardation, mental illness, 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.
- Dependents eligible for continued coverage under New York State or Federal laws.

**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 document.
- 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.**

| | | |
|---|---|---|
| **SIGN HERE** | Applicant signature<br>x | Date (mo/day/yr) |