oscar | business

# New York
# Business Enrollment Form

## Section A: Business Information

| Business name | | Doing Business As (if applicable) | |
|---|---|---|---|
| Business Address (Not P.O. Box) | | | |
| City | State | Zip Code | County |
| Federal Tax ID Number | SIC Code (optional) | Nature of Business (optional) | |

Business Classification
☐ S Corp ☐ C Corp ☐ Non-Profit ☐ Partnership ☐ Sole Proprietor ☐ LLC ☐ LLP ☐ Other: _____

Was this business established within the last year?
☐ No ☐ Yes If yes, date business was established _____ (mm/dd/yyyy)

## Section A.1: Business Contacts (please include the person(s) responsible for managing the business's benefits)

| First Name | Last Name | | Job Title |
|---|---|---|---|
| Email | Phone No | Ext. | Fax No |

Is this person also the billing contact? ☐ No ☐ Yes
Is their mailing address different then the business's address? ☐ No ☐ Yes If yes, please complete the information below:

| Address | | |
|---|---|---|
| City | State | Zip Code |

Additional Business Contact (optional)

| First Name | Last Name | | Job Title |
|---|---|---|---|
| Email | Phone No | Ext. | Fax No |

Is this person also the billing contact? ☐ No ☐ Yes
Is their mailing address different then the business address? ☐ No ☐ Yes If yes, please complete the information below:

| Address | | |
|---|---|---|
| City | State | Zip Code |

Business Tax ID: _____

## Section A.2: Business Affiliates

If the business has any affiliates that qualify as a single employer under subsection (b), (c), (m) or (o) of the Internal Revenue Code, Section 414, please complete the information below for each affiliated entity.

| Legal Name | Tax Identification Number | Number of Employees |
|---|---|---|
| | | |
| | | |
| | | |

## Section A.3: Agent/Producer/Broker Certification (to be completed by the appointed agent/broker)

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 No. | | Phone No. | |
| Email Address | | Email Address | |
| Commission percentage (if splitting with a second broker): | | Commission percentage (if splitting with a second broker): | |
| Signature | Date (mo/day/yr) | Signature | Date (mo/day/yr) |

## General Agent/Producer/Broker Use Only

General Agency Name

## General Agency Representatives

General Agency Representative Name

Email Address

Business Tax ID: _____

## Section B: Eligibility and Enrollment[1]

What is your preferred effective date of coverage? ____ / ____ / ____ (mo/day/yr)
*Note: The effective date of coverage may be the 1st or the 15th of the month. Your business's effective date requires approval from Oscar's Eligibility Team*

Total number of **full-time equivalent (FTE) employees**[2] over the previous calendar year?
(including employed owners/officers and part-time employees; excluding COBRA)

| Total number of **eligible** employees? | Total number of eligible employees **enrolling** in coverage? |
|---|---|

| Do you wish to offer Dependent child coverage from age 26 through age 29? ☐ No ☐ Yes | Do you wish to offer coverage for Domestic Partners? ☐ No ☐ Yes |
|---|---|

Did your business have 20 or more total employees during at least 50% of the working days in the previous calendar year?[3] ☐ No ☐ Yes

If yes, your business is subject to COBRA. If no, your business is subject to NY State Continuation of Coverage.

Will (or did) your business have at least 20 full-time and part-time employees for at least 20 weeks in the current or last calendar year?[4] ☐ No ☐ Yes

## Section B.1: Minimum Participation Requirements

These are the Minimum Participation requirements that apply to your business:

- If the business **will not** require employees to contribute towards premiums, **100% of the eligible employees must enroll** for Oscar coverage.
- If the business **will** require employees ot contribute towards premiums, **60% of the eligible employees must enroll** for Oscar coverage.

*Note: Employees who decline coverage under this plan because of a valid waiver do not count towards the business's minimum participation rate. An employee has a valid waiver if he or she has coverage under a spouse's plan, a parent's plan, Medicaid, Medicare, or a Veteran's plan.*

[1] Oscar requires certain forms of proof to establish eligibility. Please contact us at 1-855-672-2784 for our details regarding eligibility categories and required forms of proof. At least one (1) eligible, active, full-time employee must be enrolled (excluding officers/owners). Oscar reserves the right to request additional documentation to confirm number of hours worked and other relevant information when verifying group size/eligibility for participation.

[2] The FTE employee counting method in 26 U.S.C. § 480H(c)(2) must be utilized to determine group size for medical coverage. For more information, refer to Oscar's Underwriting Guidelines.

[3] Use the FTE employee counting method described above.

[4] Include all full-time employees, part-time employees, seasonal employees, temporary employees, union workers, owners, partners and officers. Exclude self-employed persons, independent contractors (1099), directors and leased employees. Unlike the FTE counting method above, here, each included employee counts as one.

Business Tax ID: _____

## Section C: Medical Coverage Selection

| ☐ Market Platinum | ☐ Market Gold | ☐ Market Silver |
|---|---|---|
| Office Visits<br>a. PCP: $15<br>b. Specialist: $35 | Office Visits<br>a. PCP: $25 after deductible<br>b. Specialist: $40 after deductible | Office Visits<br>a. PCP: $30 after deductible<br>b. Specialist: $50 after deductible |
| Deductible (single/family): $0/$0 | Deductible (single/family): $600/$1,200 | Deductible (single/family): $2,000/$4,000 |
| Max Out-of-Pocket (single/family): $2,000/$4,000 | Max Out-of-Pocket (single/family): $4,000/$8,000 | Max Out-of-Pocket (single/family): $6,750/$13,500 |
| Coinsurance: 10% | Coinsurance: 20% after deductible | Coinsurance: 30% after deductible |
| Emergency Room: $100 | Emergency Room: $150 after deductible | Emergency Room: $250 after deductible |
| Prescription Drug Coverage (30-day supply)<br>Tier 1: $10<br>Tier 2: $30<br>Tier 3: $60 | Prescription Drug Coverage (30-day supply)<br>Tier 1: $10<br>Tier 2: $35<br>Tier 3: $70 | Prescription Drug Coverage (30-day supply)<br>Tier 1: $10<br>Tier 2: $35<br>Tier 3: $70 |
| **☐ Market Bronze** | **☐ Simple Platinum** | **☐ Simple Gold** |
| Office Visits<br>a. PCP: 50% coinsurance after deductible<br>b. Specialist: 50% coinsurance after deductible | Office Visits<br>a. PCP: $10<br>b. Specialist: $50 | Office Visits<br>a. PCP: $10<br>b. Specialist: $50 |
| Deductible (single/family): $4,000/$8,000 | Deductible (single/family): $1,500/$3,000 | Deductible (single/family): $3,000/$6,000 |
| Max Out-of-Pocket (single/family): $7,150/$14,300 | Max Out-of-Pocket (single/family): $1,500/$3,000 | Max Out-of-Pocket (single/family): $3,000/$6,000 |
| Coinsurance: 50% after deductible | Coinsurance: N/A | Coinsurance: N/A |
| Emergency Room: 50% after deductible | Emergency Room: $0 after deductible | Emergency Room: $0 after deductible |
| Prescription Drug Coverage (30-day supply)<br>Tier 1: $10 after deductible<br>Tier 2: $35 after deductible<br>Tier 3: $70 after deductible | Prescription Drug Coverage (30-day supply)<br>Tier 1: $0<br>Tier 2: $50<br>Tier 3: $0 after deductible | Prescription Drug Coverage (30-day supply)<br>Tier 1: $0<br>Tier 2: $50<br>Tier 3: $0 after deductible |
| **☐ Simple Silver** | **☐ Simple Bronze** | |
| Office Visits<br>a. PCP: $10<br>b. Specialist: $50 | Office Visits<br>a. PCP: $0 after deductible<br>b. Specialist: $0 after deductible | |
| Deductible (single/family): $7,150/$14,300 | Deductible (single/family): $7,150/$14,300 | |
| Max Out-of-Pocket (single/family): $7,150/$14,300 | Max Out-of-Pocket (single/family): $7,150/$14,300 | |
| Coinsurance: N/A | Coinsurance: N/A | |
| Emergency Room: $0 after deductible | Emergency Room: $0 after deductible | |
| Prescription Drug Coverage (30-day supply)<br>Tier 1: $0<br>Tier 2: $50<br>Tier 3: $0 after deductible | Prescription Drug Coverage (30-day supply)<br>Tier 1: $5<br>Tier 2: $0 after deductible<br>Tier 3: $0 after deductible | |

*Note: Pediatric Dental coverage is included in all medical plans*

Business Tax ID: _____

## Section D: Waiting Period and Contribution Amount

Select the waiting period for new employees*:

- ☐ No waiting period
- ☐ 30 days after the date of hire
- ☐ 60 days after the date of hire
- ☐ 90 days after the date of hire
- ☐ 1st of month after the date of hire
- ☐ 1st of month 30 days after the date of hire
- ☐ 1st of month 60 days after the date of hire

Choose the employer medical premium contribution amount for each month:

_____% or $_____

*Note: No employer contribution is required*

*Coverage will begin on the 1st or the 15th of the month according to the group's billing cycle. However, if you choose a 90 day waiting period, coverage will begin 90 days after the date of hire.

## Section E: Prior Carrier Coverage

If this plan is a total replacement of any existing group plans, please list the carrier and relevant information below:

| Prior Carrier Name | Start Date (mo/day/yr) | End Date (mo/day/yr) |
|---|---|---|
| | | |
| | | |

## Section F: General Agreement

**Please read this section carefully before signing the application**

As an administrator of an Employee Welfare Benefit Plan under the Employee Retirement Income Security Act of 1974 (ERISA), we understand that any dispute involving an adverse benefit decision may be subject to voluntary binding arbitration only after the ERISA appeals procedure has been completed.

If we are an administrator of an Employee Welfare Benefit Plan that is a church plan or governmental plan as defined under ERISA, we understand that coverage is not subject to ERISA.

We apply to obtain the coverage designated herein.

To the best of our knowledge and belief, all information on this application is true and complete, and Oscar may rely on this application in deciding whether to provide coverage. If the application is not complete, Oscar reserves the right to reject it and notify us in writing. We understand and agree that no coverage will be effective before the date determined by Oscar, and that such coverage will be effective only if we have paid our first month's premium and this application is accepted. We further understand and agree that we should keep prior coverage in force until notified of acceptance in writing by Oscar and that no agent has the right to accept this application or bind coverage. If this application is accepted, it becomes a part of our contract with Oscar.

If we decide to cancel our group coverage after coverage has been issued, we understand that the cancellation will become effective on the last day of the month in which Oscar received the written notification of cancellation, and that no premiums will be refunded for any period between Oscar's receipt of the notification and the last day of the month when the cancellation takes effect. If there are any premiums paid after the cancellation date, we understand that Oscar will refund these premiums.

In addition, the Brokers named on this application are hereby authorized to process any enrollment transactions for the company's Oscar coverage upon direction from the authorized group representative (including, but not limited to, member enrollment, member terminations, member address changes, group contact changes, group address changes, plan renewal changes, and group contract terminations). This authorization shall be effective immediately and we agree that the company will be bound by the actions performed by the herein-named Broker pursuant to the signature below. Additionally, we acknowledge that we must notify Oscar in writing to void this agreement in the event of a change in the company's Broker of Record.

**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 | Business Administrator signature | Printed Name | Title | Date (mo/day/yr) |
|---|---|---|---|---|
| | Accepted by Oscar Authorized Representative | Printed Name | | Date (mo/day/yr) |