Nongroup Enrollment/Change Request **New York Off-Exchange**

Choose your plan

- Simple Secure
- Simple Bronze
- Simple Silver
- Simple Gold
- Simple Platinum
- Market Bronze
- Market Silver
- Market Gold
- Market Platinum

Select if you'd like to purchase a rider to cover dependent(s) aged 26-29

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 (see back for info)

Type of Activity

- Add dependent
- Remove dependent
- Change benefit plan
- Marital status change
- Update name and/or address
- Special enrollment period (following a triggering event, see list in instructions)

Requested Start Date _____/_____/_________

Date of Event _____/_____/_________

Reason

Choose your plan

*If you have a disabled dependent over age 26, please contact us at brokers@hioscar.com to request a disabled dependent form

	Name (First, Middle Initial, Last)	Is dependent disabled?*	Gender (M/F)	Social Security No.	Date of Birth (MM/DD/YYYY)	Enrolled in Medicare?
Applicant						
Spouse						
Child dependent(s)						

Just a few more questions

Home address	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

GA / Broker info (if applicable)

	Name	Writing number	Agency name	Phone	Email
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 10 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 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. 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 for making changes to your contract

1. Write the current contract holder's information (name, address, date of birth, gender, SSN, phone, and email).

   Exception: if you are making a change to the contract holder's name or address, please write the new name or address (see below for further instructions).
2. Enter current Oscar member ID.
3. Follow the instructions below for the specific change you want to make.
4. Enter the month you want the change to take effect in the "Effective Date of Coverage" field.

Adding a dependent

- Check the "Add Dependent" box.
- Indicate the date of qualifying event:
  - Date of birth or adoption (Congrats!).
  - Date other health insurance coverage was lost.
- Enter the new dependent's information in the eligible family members section.

Removing a dependent

- Check the "Remove Dependent" box.
- Enter the information of the dependent being removed in the eligible family members section.

Updating name and/or address

- Check the "Update Name and/or Address" box.
- If changing the contract holder's name and/or address: Enter the new name/address in the appropriate fields at the top of the form. Please include all other identifying information as well (date of birth, SSN, telephone number, email address).
- If changing the name of a dependent: Enter the new name of the dependent in the appropriate field under the eligible family members section. Please include the other identifying information as well (gender, SSN, and date of birth).

Changing benefit plan

- Check the "Change Benefit Plan" box.
- Enter the contract holder's information in the appropriate fields at the top of the form.
- In the choose your plan section at the top, indicate the plan you'd like to switch into. Please be aware that if your contract is an Individual & Spouse, Parent & Child(ren), or Family, the change will be applied to everyone on the contract.

Marital status change

- Check the "Marital Status Change" box.
- Indicate the date on which your marital status changed.
- If you're including a new family member (spouse or domestic partner), check the "Add Dependent" box and enter the new family member's information in the eligible family members section.
- If you're removing an existing family member, check the "Remove Dependent" box and enter the information of the person being removed in the eligible family members section.

Eligibility

1. You must not be enrolled in Medicare.
2. Pediatric dental is a mandatory Essential Health Benefit under the Affordable Care Act (ACA) and is automatically included in all Oscar plans. Benefits are provided to any covered person under the age of 19.

Triggering events

1. Loss of eligibility for minimum essential coverage but not if lost due to non-payment of premium
2. Dependent attained age 26 and lost coverage
3. Marketplace changed your subsidy determination
4. New dependent due to marriage, domestic partnership, birth, adoption, placement for adoption, or a child support order or other court order.
5. Gained access to New York plans as a result of permanent move to New York
6. No longer incarcerated
7. Became lawfully present
8. Gained status as an Indian
9. Enrollment or non-enrollment in another qualified health plan was unintentional, inadvertent, or erroneous and was the result of the error, misrepresentation, or agent of a health plan or the Exchange
10. Can demonstrate another qualified health plan in which prospective member was enrolled substantially violated a material provision of its contract
11. Became pregnant as certified by a health care professional and previously did not have health insurance

For a list of qualifying event documentation, please see **hioscar.com/brokers/resources**

Child only plan

You must list a responsible party if the subscriber is under 18. Please put this responsible party information in the Applicant field and the child's information in the Child dependent(s) field. Please make sure to select "Child only" under the "Who are you buying insurance for?" section. Note that you can only pick a standard metal plan for a child only plan. Also, there can only be one child per child only plan.

Special enrollment – Qualifying life event guidelines

All SEP enrollees are required to provide documentation of their qualifying life event (QLE) according to the chart below. Brokers should collect this documentation from their client at the time of sale, review for validity, and submit to their General Agent along with this application. All documentation will be audited by Oscar.

<table>
<tr><th>Qualifying event</th><th>Required Documentation</th><th>Effective date of coverage</th></tr>
<tr><td colspan="3">Loss of minimal essential coverage</td></tr>
<tr><td>Lost your job (voluntarily or involuntarily)
Employer stopped offering health insurance
Insurance through employer is no longer affordable or is no longer minimum essential coverage</td><td>Termination notice from prior employer/insurer indicating loss of coverage</td><td rowspan="6">Either:
• 1st of the month following event, or
• 1st of month following date Oscar receives application</td></tr>
<tr><td>Aging out</td><td>Letter from prior carrier indicating a person is aging out</td></tr>
<tr><td>Divorce, annulment, legal separation, or end of domestic partnership</td><td>Copy of divorce decree or other relevant proof</td></tr>
<tr><td>Death of a spouse</td><td>Copy of death certificate</td></tr>
<tr><td>COBRA coverage terminated</td><td>Letter from COBRA administrator or prior carrier indicating loss of COBRA coverage</td></tr>
<tr><td>No longer eligible for Medicaid or Child Health Plus</td><td>Letter from Medicaid/CHP indicating loss of coverage</td></tr>
<tr><td colspan="3">Non-loss of coverage events</td></tr>
<tr><td>Moved into Oscar's service area</td><td>Proof of residence from both new address and old address. Proof of residence from old address must be dated within the past 120 days and proof of residence from new address must be from within the previous 45 days.</td><td>Either:
• 1st of the month following event, or
• 1st of month following date Oscar receives application</td></tr>
<tr><td>Gained a dependent through marriage or domestic partnership</td><td>Copy of marriage certificate or certificate of domestic partnership. If domestic partnership registration does not exist in coverage area, please see Oscar's off exchange certificate of coverage for alternate means of establishing proof of domestic partnership.</td><td>1st of month following date Oscar receives application</td></tr>
<tr><td>Gained a child dependent or became a child dependent through birth, adoption, placement for adoption, a child support order or another court order</td><td>Copy of birth/adoption certificate or proof of birth from hospital reflecting date of birth. Copy of court order or child support order.</td><td>If Oscar receives notice of birth/adoption within 60 days of birth, member may choose effective date:
• 1st of month in which event occurs,
• 1st of month following event,
• 1st of month after plan selection if that is later than the first two options,
• 1st of following month after plan selection if that is later than the first two options.
If Oscar receives notice after 60 days, coverage begins on the 1st of month in which Oscar receives the application.</td></tr>
</table>

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Qualifying event	Required Documentation	Effective date of coverage
Non-loss of coverage events (continued)		
Pregnancy	Certification from healthcare provider	1st of month in which you become certified as pregnant, or 1st of month following certification
Released from incarceration	Proof of release from incarceration	If signup between 1st-15th of month: 1st of month following date Oscar receives the application If signup between 16th-end of month: 1st of 2nd month following date Oscar receives the application
Became lawfully present	Proof of lawfully present status. Please see: healthcare.gov/immigrants/lawfully-present-immigrants/ for more details	
Member of a federally recognized Indian tribe	Proof of status	
Enrollment or non-enrollment in another qualified health plan was unintentional, inadvertent or erroneous and was the result of the error, misrepresentation, or inaction of an officer, employee, or agent of a health plan or the Exchange	Letter from Exchange verifying eligibility to enroll in a new plan	
Can demonstrate another qualified health plan in which prospective member was enrolled substantially violated a material provision of its contract.	Letter from Exchange verifying eligibility to enroll in a new plan	
Determined newly eligible or newly ineligible for advance payments of the premium tax credit or have a change in eligibility for costsharing reductions	Letter from the Exchange indicating eligibility change for advanced premium tax credits or cost-sharing reduction plans	

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