



Nongroup Enrollment/Change Request California Off-Exchange

Choose your plan

- Oscar Saver Silver HSA EPO
- Oscar Simple Bronze EPO
- Oscar Simple Gold EPO
- Oscar Simple Silver EPO
- Oscar Minimum Coverage EPO
- Oscar Bronze 60 HDHP EPO
- Oscar Bronze 60 EPO
- Oscar Gold 80 EPO
- Oscar Platinum 90 EPO
- Oscar Silver 70 EPO

Note: Pediatric Dental coverage is included in all plans

Oscar ID (if changing an existing plan)

Who are you buying insurance for?

- Individual
- Parent & Child(ren)
- Child Only
- Individual & Spouse
- Family

Type of Activity

- Add dependent
- Change benefit plan
- Update name and/or address
- Remove dependent
- Marital status change
- New enrollment
- Special enrollment period (following a QLE, 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?
Applicant		<input type="checkbox"/>						<input type="checkbox"/>
Spouse		<input type="checkbox"/>						<input type="checkbox"/>
Child dependent(s)		<input type="checkbox"/>						<input type="checkbox"/>
		<input type="checkbox"/>						<input type="checkbox"/>
		<input type="checkbox"/>						<input type="checkbox"/>
		<input type="checkbox"/>						<input type="checkbox"/>
		<input type="checkbox"/>						<input type="checkbox"/>
		<input type="checkbox"/>						<input type="checkbox"/>

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

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 <input type="radio"/> Single <input type="radio"/> Married <input type="radio"/> 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	National Producer Number (NPN)	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 30 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

- 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 2019 coverage, the Annual Open Enrollment Period runs from October 15, 2018 through January 15, 2019.
- 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.

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 signing, review for validity, and submit to their General Agent along with this application. All documentation will be audited by Oscar. All submitted documents must be dated and include the member's name. E-mails are not an acceptable form of documentation. We will accept documents via E-mail; however, we cannot accept the E-mail itself as a form of proof. Oscar reserves the right to request additional documentation.

Qualifying event	Required Documentation	Effective date of coverage
Loss of minimal essential coverage		
Lost your job (voluntarily or involuntarily)	<ul style="list-style-type: none"> Termination notice from prior insurer AND Letter from employer indicating loss of employment 	Either: <ul style="list-style-type: none"> 1st of the month following event, or 1st of month following date Oscar receives application whichever comes later
Employer stopped offering health insurance	<ul style="list-style-type: none"> Termination notice from prior insurer AND Letter from employer indicating loss of coverage 	
Insurance through employer is no longer affordable	<ul style="list-style-type: none"> Current Pay stub AND Premium invoice from prior carrier AND Federal tax returns 	
Insurance through employer no longer meets minimum essential coverage guidelines	<ul style="list-style-type: none"> Termination notice from prior insurer AND Documentation with detailed benefits and coverage information (e.g. Explanation of Coverage (EOC), Summary of Benefits and Coverage (SBC), Schedule of Benefits (SOB), etc.) 	
Aging out	Letter from prior carrier indicating a person is aging out	
Divorce, annulment, legal separation, or end of domestic partnership	Copy of divorce decree	
Death of a spouse	Copy of death certificate	
COBRA coverage terminated	Letter from COBRA administrator or prior carrier indicating loss of COBRA coverage	
No longer eligible for Medicaid or Child Health Plus	Letter from Medicaid/CHP indicating loss of coverage	
No longer eligible for student health coverage	<ul style="list-style-type: none"> Proof of coverage from prior insurer OR Proof of University terminating coverage Note: E-mails from the university are acceptable for QLE proof	
Returned from active military duty or California National Guard	<ul style="list-style-type: none"> An official document on military letterhead indicating when member was discharged OR Letter from TRICARE indicating date of coverage termination 	
Provider left Health Plan Your provider left the health plan network while you were receiving care for one of the following conditions: <ul style="list-style-type: none"> Pregnancy Terminal illness An acute condition A serious chronic condition The care of a newborn child between birth and age 36 months A surgery or other procedure that will occur within 180 days of the termination or start date 	Proof of coverage through prior carrier and letter from physician indicating they left previous insurer's network <ul style="list-style-type: none"> NOTE: Letter from provider must indicate that they are no longer in member's prior issuer's network and must include that member is receiving services for an acute condition, serious chronic condition, pregnancy, terminal illness, the care of a newborn child between birth and 36 months, or performance of a surgery or other procedure that has been authorized by their previous plan and is documented by the provider to occur within 180 days of the contract's termination date. Letter from issuers must indicate that provider is no longer in network. 	

Qualifying event

Required Documentation

Effective date of coverage

Non-loss of coverage events

<p>Permanent move/relocation from outside of Oscar's coverage area and/or from another state AND had minimum essential coverage for one or more days in the 60 days prior to the move</p>	<ul style="list-style-type: none"> • Proof of prior insurance by providing a disenrollment notice from the prior insurer AND • Proof of prior residential address AND • Proof of new residential address. • Proof must be dated. Recommended documentation: <ul style="list-style-type: none"> • Mortgage Bill • Renter's Agreement with new residential address and occupancy date • Driver's License with new residential address • Utility Bill (electric, gas, phone, cable, internet) with new residential address showing service start up charges • Postal Service change of address receipt (old address/new address/effective date) • Moving company receipt (indicates prior and current addresses) • Proof of residence from new address must be from within the previous 60 days 	<p>1st of month following the move, or 1st of month following date Oscar received application (whichever is later)</p>
<p>Permanent move/relocation from another country to Oscar's coverage area</p>	<ul style="list-style-type: none"> • Proof of prior residential address AND • Proof of new residential addresses AND • Dated proof of moving/returning to US Residential address by providing ONE of the following: <ul style="list-style-type: none"> • Copy of Naturalization Papers • Copy of Green Card, VISA • Copy of US passport with date stamp of returning to US • Green card • Educational Certificate from originating country (within 90 days) • Specific types of Visa are unacceptable: B1, B2, GB, GT, H-2A, H-2B, H-3, H-4, WB, WT 	
<p>Recent marriage or domestic partnership</p>	<ul style="list-style-type: none"> • Copy of Marriage Certificate OR • Copy of an affidavit of domestic partnership. If domestic partnership registration does not exist in coverage area, please provide ONE of the following alternative means of establishing proof of domestic partnership: notarized affidavit, proof of cohabitation, proof of financial interdependency. <p>AND</p> <ul style="list-style-type: none"> • Proof of cohabitation (e.g. lease with both names) • Proof of financial interdependence from the past 60 days (e.g. credit card or bank statement with name of both parties) 	<p>1st of month following date Oscar receives application</p>

Qualifying event

Required Documentation

Effective date of coverage

Non-loss of coverage events (continued)		
Gained a child dependent or became a child dependent through birth, adoption, placement for adoption, a child support order or another court order	Copy of birth/adoption certificate or proof of birth from hospital reflecting date of birth. Copy of court order or child support order.	<p>If Oscar receives notice of birth/adoption within 60 days of birth, member may choose effective date:</p> <ul style="list-style-type: none"> • Date of birth • 1st of month following birth <p>If Oscar receives notice after 60 days, member will need to wait until open enrollment to add dependent.</p>
Released from incarceration	Proof of release from incarceration	<p>If signup is between 1st-15th of month: 1st of month following date Oscar receives the application</p> <p>If signup is between 16th-end of month: 1st of 2nd month following date Oscar receives the application</p>
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	<p>Was enrolled On-Exchange:</p> <ul style="list-style-type: none"> • Letter from Exchange verifying eligibility to enroll in a new plan <p>Was enrolled Off-Exchange:</p> <ul style="list-style-type: none"> • Letter from prior issuer detailing the error 	
Can demonstrate another qualified health plan in which prospective member was enrolled substantially violated a material provision of its contract	<p>Was enrolled On-Exchange:</p> <ul style="list-style-type: none"> • Letter from Exchange verifying eligibility to enroll in a new plan <p>Was enrolled Off-Exchange:</p> <ul style="list-style-type: none"> • Letter from prior issuer detailing the error 	
Determined newly eligible or newly ineligible for advance payments of the premium tax credit	<ul style="list-style-type: none"> • Letter from exchange or appropriate government body indicating eligibility AND • Reason for eligibility change 	