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

Choose your plan

- ○ Simple Secure
- ○ Simple Bronze
- ○ Simple Silver
- ○ Simple Gold
- ○ Backup Bronze
- ○ Backup Gold
- ○ Classic Bronze
- ○ Classic Silver
- ○ Classic Gold
- ○ Classic Platinum
- ○ Backup Silver

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
- ☐ New enrollment
- ☐ 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 QLE ____/____/_____

Qualifying life event (if applicable)

Who's Covered

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

* If you have a disabled dependent over age 26, please contact us at brokers@hioscar.com to request a disabled dependent form
** Within the past 6 months have you regularly used tobacco (4 or more times per week on average excluding religious or ceremonial use)? Note that when determining your premium, Oscar may consider whether you smoke or use tobacco.

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

Do you maintain a home in another state or county? ○ Yes ○ No

Are you a Texas resident? ○ Yes ○ No

GA / Broker info (if applicable)

	Name	Writing number or National Producer Number (NPN)	Agency name	Phone	Email
GA					
Broker	Gary Victorson	BR10840	Victorson Associates, Ir	631-265-7456	gary@victorson.com
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

- 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 Triggering Event.
- Eligible for Medicare means the person satisfies the requirements for Medicare but has not yet enrolled in Medicare. Covered 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.

Triggering Events

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 Texas plans as a result of permanent move to Texas
6. No longer incarcerated
7. Became lawfully present
8. Gained status as an Indian

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

Eligibility

- You must not be enrolled for Medicare Parts A or B.
- If application is made for the Catastrophic Plan the following additional requirements apply
  1. You must be under 30 years old; OR
  2. You must have a Certificate of 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 family members who are currently uninsuredor who are covered under another individual plan, or who are covered under a group health plan, group health benefits plan, a governmental plan, or a church plan and wish to switch to Oscar. Your application must be received during the designated Annual Open Enrollment Period, unless you've experienced a Triggering Event. For 2017 coverage, the Annual Open Enrollment Period runs from November 1, 2017 through January 31, 2018. You must enroll prior to December 31 for coverage to begin on January 1.
- A Special Enrollment Period that lasts for 60 days follows the Triggering Events listed above. The effective date of a new policy will be no later than the first of the month following receipt of the application. In addition, if the Triggering Event is the loss of eligibility for minimum essential coverage, the Special Enrollment Period includes the 60 days prior to the Triggering Event.
- Pediatric dental is a mandatory Essential Health Benefit under the Affordable Care Act (ACA) and must be included unless you can attest that you receive ACA compliant Pediatric Dental coverage elsewhere. Benefits are provided to any covered person under the age of 19 and will require an additional cost beyond your health plan coverage premium. Note: the charge may apply even if no one in your family who is covered is under the age of 19.
- Note: If you currently have coverage the plan for which you are applying must replace the current coverage but you should not terminate it until the new coverage is effective.

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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)	• Termination notice from prior insurer AND • Letter from employer indicating loss of employment	Either: • 1st of the month following event, or • 1st of month following date Oscar receives application whichever comes later
Employer stopped offering health insurance	• Termination notice from prior insurer AND • Letter from employer indicating loss of coverage	
Insurance through employer is no longer affordable	• Current Pay stub AND • Premium invoice from prior carrier AND • Federal tax returns	
Insurance through employer no longer meets minimum essential coverage guidelines	• 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	• Proof of coverage from prior insurer OR • Proof of University terminating coverage Note: E-mails from the university are acceptable for QLE proof	
Victim of domestic abuse or spousal abandonment	Documentation is not required	

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Qualifying event	Required Documentation	Effective date of coverage
Non-loss of coverage events		

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	• Proof of prior insurance by providing a disenrollment notice from the prior insurer AND
	• Proof of prior residential address AND new residential address. Proof must be dated. Recommended documentation:
	  • 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
		1st of month following the move, or 1st of month following date Oscar received application (whichever is later)

Permanent move/relocation from another country to Oscar's coverage area	• Prior and new residential addresses AND
	• Dated proof of moving/returning to US Residential address by providing ONE of the following:
	  • 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	

Recent marriage or domestic partnership	• 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. AND • 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)	1st of month following date Oscar receives application

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.	If Oscar receives notice of birth/adoption within 60 days of birth, member may choose effective date: • Date of birth • 1st of month following birth If Oscar receives notice after 60 days, member will need to wait until open enrollment to add dependent.
Released from incarceration	Proof of release from incarceration	If signup is between 1st-15th of month: 1st of month following date Oscar receives the application If signup is 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	Was enrolled On-Exchange: • Letter from Exchange verifying eligibility to enroll in a new plan Was enrolled Off-Exchange: • 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	Was enrolled On-Exchange: • Letter from Exchange verifying eligibility to enroll in a new plan Was enrolled Off-Exchange: • Letter from prior issuer detailing the error	
Determined newly eligible or newly ineligible for advance payments of the premium tax credit	• Letter from exchange or appropriate government body indicating eligibility AND • Reason for eligibility change	