oscar 295 Lafayette St. 6th Floor | NY, NY 10012

# Individual Enrollment Application/Change Form (Off Exchange)

**Choose your plan**

○ Bronze ○ Bronze Edge+ ○ Silver Edge ○ Gold
○ Bronze Edge ○ Silver ○ Silver Edge+ ○ Gold Edge
☐ *Select if you're covering a dependent aged 26 - 29*

**Who are you buying insurance for?**

○ Individual ○ Individual & Spouse
○ Parent & Child(ren) ○ Family

| Last Name | First Name | MI | Date of Birth (MM/DD/YYYY) | Gender | Social Security No. |
|---|---|---|---|---|---|
| | | | | ○ Male ○ Female | |

| Home Address | Apt # | City | County | State | Zip Code |
|---|---|---|---|---|---|
| | | | | | |

| Telephone: Home / Cell | Email Address | Marital Status: |
|---|---|---|
| | | ☐ Single ☐ Married ☐ Domestic Partner |

**Mailing address, if different from home address**

| Name | Address | Apt # | City | County | State | Zip Code |
|---|---|---|---|---|---|---|
| | | | | | | |

**Make changes to your current plan**

Please see the back of this form for instructions on how to make a change

☐ Add Dependent ☐ Remove Dependent ☐ Update Name and/or Address ☐ Leaving Oscar ☹ ☐ Change Benefit Plan ☐ Marital Status Change

Date of Event (dependent / marital status change)

**Effective Date of Coverage:** ____/ 01 /2014

Oscar Member ID (if making change to plan)

*If you or any of your eligible family members currently have health insurance or have had it in the past 12 months, please provide the following:*

| List Eligible Family Members Below (First name, Middle Initial, Last name) | | Disabled Dependent (over age 26*) | Gender (M/F) | Social Security No. | Date of Birth (MM/DD/YYYY) | Carrier Name | Group Number | Member ID | Effective Dates |
|---|---|---|---|---|---|---|---|---|---|
| Applicant | | | | | | | | | From: To: |
| Spouse | | | | | | | | | From: To: |
| Child Dependent | | ☐ | | | | | | | From: To: |
| | | ☐ | | | | | | | From: To: |
| | | ☐ | | | | | | | From: To: |
| | | ☐ | | | | | | | From: To: |
| | | ☐ | | | | | | | From: To: |
| | | ☐ | | | | | | | From: To: |

*Please call us at 1-855-OSCAR-55 to request a disabled dependent form

**GA / Broker Information (if applicable)**

| GA Name | GA License Number | GA Agency Name | Phone | Email |
|---|---|---|---|---|
| Broker's Name | Broker License Number | Broker's Agency Name | Phone | Email |
| Co-Broker's Name | Co-Broker's License Number | Co-Broker's Agency Name | Phone | Email |

**Please Read the Following 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

Return to:

oscar

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# Instructions for making changes to your contract

1. Write the current contract holder's information at the top of the form (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 in the middle of the form.
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).

### Leaving Oscar

- If you really must go, check the "Leaving Oscar" box. We'll miss you!
- Enter the contract holder's information in the appropriate fields at the top of the form.

### 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.