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Business Enrollment Form - California 2018

Instructions

The attached forms should be completed with the assistance of your authorized Broker or Oscar Sales Representative. Please complete all necessary forms in their entirety. Please print in ink or type your responses and ensure that all areas requiring a signature and date are complete.

Completed enrollment application forms should be entered on the Oscar enrollment portal (business.hioscar.com) prior to your effective date. This can be completed by your Broker or an Oscar Sales Representative.

Required documents

Please complete the following documents to enroll with Oscar. All application data and forms must be entered into the Oscar enrollment portal at business.hioscar.com. Oscar does not accept any paper forms by mail or fax.

- ☐ **Business Enrollment Form - California 2018**
  This can be completed online in the Oscar enrollment portal.

- ☐ **Payroll verification through appropriate tax documentation (required for all groups)**
  DE9C is required for groups for all enrolling groups. If the DE9C is not available, four weeks of payroll will suffice. All payroll verifications must be scanned and uploaded to the portal. If group is enrolling two members or fewer, you must also include proof of ownership.

- ☐ **California Employee Enrollment application(s)**
  One application should be completed for each enrolling employee or COBRA/Cal-COBRA recipient. These applications can be completed entirely online by employees - or completed on paper and then entered in the portal by the authorized Broker or GA.

- ☐ **Employee Waiver form(s) and applicable waiver documentation**
  One form is needed for each employee waiving or refusing coverage. Waivers may be completed online in the Oscar enrollment portal.

- ☐ **ACH Authorization Form**
  This document is page seven in this file. It is optional but highly encouraged to expedite member ID card delivery. ACH payments can be setup for automatic deduction on the first of every month or can be uploaded solely for an automatic first payment. If the group wishes to pay the first premium via check, they must wait for approval and the first bill generation and delivery. The first premium check will then have to be mailed in along with the bill stub to the following address:

  Oscar Health Plan of California
  PO Box 740703
  Los Angeles, CA 90074-0703

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Section A: Business information

Business name		Doing business as (if applicable)	
Business address (Not P.O. Box) line 1		Business address line 2	
City	State	ZIP code	County
Mailing address (if different from address above) line 1		Mailing address line 2	
City	State	ZIP code	County
Federal Tax ID number	SIC code (optional)	Nature of business (optional)	

Business classification (choose one)

☐ S Corp ☐ Non-Profit ☐ Sole Proprietor ☐ LLP

☐ C Corp ☐ Partnership ☐ LLC ☐ Other (please explain):

Was this business established within the last year?

☐ No ☐ Yes

(Note: If this business was established less than 4 weeks from the effective date, they are not eligible for insurance)

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 and online accounts)

First name	Last name		Job title
Email	Phone	Ext.	Fax

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	Address line 2	
City	State	ZIP code

Additional business contact (optional)

First name	Last name		Job title
Email	Phone	Ext.	Fax

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 line 1	Address line 2	
City	State	ZIP code

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	Location (city and state)	Federal Tax ID number	Number of FTE	Employees enrolling

Section A.3: Agent certification (to be completed by the appointed agent)

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.

Name of writing agent /producer		**Only for commission split; second agent / producer**	
First name	Last name	First name	Last name
Agency name		Agency name	
Oscar broker ID		Oscar broker ID	
NPN (optional)		NPN (optional)	
Phone	Email	Phone	Email
Commission percentage (if splitting with a second broker):		Commission percentage (if splitting with a second broker):	
Signature X.....	Date (mm/dd/yyyy)	Signature X.....	Date (mm/dd/yyyy)

Agent use only

General agency name

General agency representatives

General agency representative name	Email

Section A.4: Prior carrier coverage

Please list all prior or existing group health insurance plans and their relevant information below:

Prior carrier name	Total replacement? (yes or no)	Start date (mm/dd/yyyy)	End date (mm/dd/yyyy)

Section B: Eligibility and enrollment

Preferred effective date of coverage (mm/dd/yyyy)?
Must be the 1st or 15th of a future month.

Coverage offered to all eligible employees working an average of: ☐ 20+ hours ☐ 30+ hours

Total number of full-time equivalent (FTE) employees[1] over the previous calendar year? (including employed owners/officers and part-time employees; excluding COBRA/Cal-COBRA)

Total number of employees	Total number of eligible employees

How many current employees will be enrolling? (excluding COBRA/Cal-COBRA members)

How many eligible employees will be submitting valid waivers? [2]

Is this business offering Oscar alongside another carrier? ☐ No ☐ Yes

→ If yes to the question above, which carrier?	→ How many employees are enrolling with them?

Are your employees contributing to their premium? ☐ No ☐ Yes

Do you offer Worker's Compensation? ☐ No ☐ Yes

Is the group currently subject to Cal-COBRA?
(Employed 2-19 eligible employees on at least 50% of its working days in the previous calendar year; or if not in business during any part of the previous calendar year, then during the previous calendar quarter) ☐ No ☐ Yes

Is the group currently subject to Federal COBRA?
(Employed 20 or more total employees on at least 50% of the working days in the previous calendar year.) ☐ No ☐ Yes

[1] The FTE employee counting method in 26 U.S.C. § 4980H(c)(2) must be utilized to determine group size for medical coverage. For more information, refer to Oscar's Underwriting Guidelines.
[2] Valid waivers include: other group insurance, coverage under parent or spouse's policy, Medicare, Medicaid, VA, individual coverage with APTC.

Section C: Medical coverage selection

Do you wish to offer coverage for infertility treatment benefits?
(Note: selecting Yes will result in a higher premium.)

☐ No ☐ Yes

Section C.1: Plan information

Select waiting period for new employees:

☐ 1st of month after the date of hire

☐ 1st of month 60 days after the date of hire, not to exceed 90 days

☐ 1st of month 30 days after the date of hire

Choose the employer medical premium monthly contribution amount for employees. If you contribute 100% of the premium, 100% of eligible employees must enroll:

_____ % or $ _____

Note: Employers are required to contribute to at least 50% or $100 of the employees premium.

Set the employer medical premium monthly contribution amount for dependents. If left blank, the employee contribution amount to the left will be applied to the subscriber's entire family:

_____ % or $ _____

Note: This section should only be filled out if you would like to contribute a different amount towards employee's dependents. Use same contribution type (% or $).

Select up to 3 plans to offer (visit hioscar.com/forms for full plan details):

☐ Bronze 60 EPO $6,300/$75 + Child Dental

☐ Bronze 60 HDHP EPO $4,800/40% + Child Dental

☐ Saver Bronze EPO + Child Dental

☐ Classic Bronze EPO + Child Dental

☐ Silver 70 EPO $2,000/$45 + Child Dental

☐ Silver 70 HDHP EPO $2,000/20% + Child Dental

☐ Classic Silver $1,500 EPO + Child Dental

☐ Classic Silver $2,000/$7,000 50% EPO + Child Dental

☐ Classic Silver $2,000/$7,350 30% EPO + Child Dental

☐ Classic Silver $2,000/$7,350 50% EPO + Child Dental

☐ Gold 80 EPO $0/$25 + Child Dental

☐ Classic Gold $1,000 EPO + Child Dental

☐ Classic Gold $2,000 EPO + Child Dental

☐ Classic Gold $500/$5,000 EPO + Child Dental

☐ Classic Gold $500/$7,000 EPO + Child Dental

☐ Platinum 90 EPO $0/$15 + Child Dental

☐ Classic Platinum $0/$4,000 EPO + Child Dental

Section D: General agreement

Please read this section carefully before signing the application:

We will distribute Evidence of Coverage booklets and other required notices to covered employees in a timely manner. Electronic versions of required materials are available to us online, to obtain printed version we may contact Oscar at (844) 567-2272.

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 Health Plan of California ("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.

Note - California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

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.

Business administrator signature	Printed name and title	Date (mm/dd/yyyy)
Sign here ×		
Agent signature	**Printed name and title**	**Date (mm/dd/yyyy)**
Sign here ×		

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ACH Authorization Form

Fill out the following form to allow Oscar to store and debit payments from your bank account. By submitting this form you are authorizing Oscar to debit the first month's full premium automatically upon approval. Subsequent payments will be deducted automatically only if auto-pay is selected. ACH payments are easy and will help get your employees their member ID cards faster and easier!

Section A: Business billing information

Billing contact (print full name)	Business name
Group number (if available)	

Section B: ACH account information

Account type ☐ Checking ☐ Savings	⑆072404333⑆ 1234567890 Routing number (9 digits) Account number
Bank name	Routing number
Account number	Confirm account number

Section C: Payment settings

☐ Enroll in auto-pay Have your bill automatically paid each month with the bank account you chose in the section above.	☐ Enroll in paperless billing Save paper and have your bill emailed to you and your team each month.

Section D: General agreement

I hereby authorize Oscar Insurance Corporation, including its parent, affiliates and subsidiaries (Oscar) to initiate entries to the checking/savings account at the financial institution listed above, and, if necessary, initiate adjustments for any transactions credited/debited in error. This authority will remain in effect until Oscar notifies me that this service has been discontinued, or I notify Oscar in writing to cancel it in such time as to afford Oscar and the financial institution a reasonable opportunity to act on my request. I agree to notify Oscar in writing of any changes in my account information at least 15 days prior to the next billing date. If payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. I understand that ACH debits to the checking/savings account are electronic transactions and funds may be withdrawn from the account as soon as the above noted periodic transaction dates. I certify that I am an authorized user of this credit card/bank account and will not dispute these scheduled transactions with my bank or credit card company as long as the transactions correspond to the terms indicated in this authorization form.

Signature of applicant Sign here ×	Printed name	Date (mm/dd/yyyy)

Notice of Non-Discrimination: Discrimination is Against the Law

Oscar complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Oscar does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Oscar:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Member Services at 1-855-OSCAR-55 (TTY: 7-1-1).

If you believe that Oscar has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

NY/NJ/TX/OH/TN Members: Oscar Insurance, Attention Grievances PO Box 52146, Phoenix AZ, 85072

CA Members: Oscar Health Plan of California, Attention Grievances 9942 Culver City Blvd., PO Box 1279, Culver City, CA 90232

1-855-OSCAR-55 (TTY: 7-1-1), Mon - Fri 8 am - 8 pm/ Sat - Sun 9 am - 5 pm (EST), Fax: 1-888-977-2062, Email: help@hioscar.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Oscar's Grievances Department is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW Room 509F,
HHH Building Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Language Assistance Services for the Deaf or Hard of Hearing

ATTENTION: If you are deaf or hard of hearing, talk to text services, free of charge, are available to you. Call 1-855-Oscar-55 and dial 711 to receive TTY/TDD services.

Multi-language interpreter services

Español (Spanish): ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-OSCAR-55.

繁體中文 (Chinese): 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-OSCAR-55.

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1–855–OSCAR–55.

Kreyòl Ayisyen (French Creole): ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-855-OSCAR-55.

한국어 (Korean): 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-OSCAR-55 번으로 전화해 주십시오.

Italiano (Italian): ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-OSCAR-55.

אידיש (Yiddish): אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויס פריי פון אפצאל. רופט 1-855-OSCAR-55.

বাংলা (Bengali): লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১ -855-OSCAR-55.

Polski (Polish): UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-855-OSCAR-55.

العربية (Arabic): ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لا بالمجان. اتصل برقم 1–855–RACSO–55.

Français (French): ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-OSCAR-55.

اُردُو (Urdu): خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 1-855-OSCAR-55

Tagalog (Tagalog – Filipino): PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-OSCAR-55.

Ελληνικά (Greek): ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-855-OSCAR-55.

Shqip (Albanian): KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-855-OSCAR-55.

Tiếng Việt (Vietnamese): CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-OSCAR-55.

हिंदी (Hindi): ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-855-OSCAR-55 पर कॉल करें।

فارسی (Farsi): توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما میباشد. با 1-855–OSCAR-55 تماس بگیرید.

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-OSCAR-55.

ગુજરાતી (Gujarati): સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-855-OSCAR-55.

日本語 (Japanese): 注意事項： 日本語を話される場合、無料の言語支援をご利用いただけます。1-855-OSCAR-55 まで、お電話にてご連絡ください。

ພາສາລາວ (Lao): ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-855-OSCAR-55.

Português (Portuguese): ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-855-OSCAR-55.

አማርኛ (Amharic): ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-855-OSCAR-55.

Հայերեն (Armenian): ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-855-OSCAR-55.

ਪੰਜਾਬੀ (Punjabi): ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-855-OSCAR-55 'ਤੇ ਕਾਲ ਕਰੋ।

ខ្មែរ (Cambodian): ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-855-OSCAR-55. ។

Hmoob (Hmong): LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-855-OSCAR-55.

ภาษาไทย (Thai): ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-855-OSCAR-55.

Deitsch (Pennsylvania Dutch): Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1–855–OSCAR–55.

Oroomiffa (Oromo): XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-855-OSCAR-55.

Nederlands (Dutch): AANDACHT: Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel 1-855-OSCAR-55.

Українська (Ukrainian): УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-855-OSCAR-55.

Română (Romanian): ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-855-OSCAR-55.