oscar

Employee Enrollment Application / Change Request Form - California 2018

Instructions: You (the employee) must complete this application. You are solely responsible for its accuracy and completeness. To avoid the possibility of delay, answer all questions and be sure to sign and date your application. Please complete this form in blue or black ink and submit to your employer when complete.

Section A: Employer information

Employer name	Employer group ID (ex: BIZ12345678 – if unavailable, leave blank)

Employee's status (check all options that apply):

☐ Active ☐ Union ☐ Non-union

☐ Hourly ☐ Salary ☐ Other (please explain):

Hours worked by employee per week	Date of hire (mm/dd/yyyy)	Hours worked per week

Section B: Application type

Application type

☐ New group application ☐ Change benefits plan ☐ Information update (name, address, etc.)

☐ Add/remove a dependent ☐ Termination

Application reason

☐ Open enrollment ☐ New hire ☐ Rehire

☐ COBRA ☐ Cal-COBRA ☐ Qualifying Life Event

☐ Other (please explain):

If you selected **COBRA** or **Cal-COBRA** as the application reason above, please select one of the following qualifying events:

☐ Left employment
☐ Reduction in hours
☐ Death
☐ Divorce or legal separation
☐ Loss of dependent child status
☐ Medicare entitlement

Continuation qualifying event date (mm/dd/yyyy):

If you selected **Qualifying Life Event** as the application reason above, please select one of the following applicable qualifying life events and its date:

☐ Loss of coverage*
☐ Marriage
☐ Birth
☐ Adoption*
☐ Court-ordered dependent addition*
☐ Moved to service area*
☐ Other (please specify):

Qualifying event date (mm/dd/yyyy):

* Indicates that appropriate documentation must be submitted along with this form to be eligible for coverage.

Section C: Member information

Instructions: The below information must be completed for the subscriber and any additional family members to be covered. An eligible dependent may be your spouse, domestic partner, your children, your spouse's children or your domestic partner's children.

Coverage of a child dependent will continue to the end of the month in which the child turns age 26 unless he or she qualifies as a disabled person (if you have a disabled dependent, please call us at (855) 672-2784 to request a disabled dependent form, or visit hioscar.com/forms).

If you would like to add additional dependents, please print another copy of this page and attach it to your application.

	Employee	Spouse	Child	Child 2
First name				
Middle initial				
Last name				
Social security number	– – ☐ No SSN	– – ☐ No SSN	– – ☐ No SSN	– – ☐ No SSN
Gender	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
Date of birth (mm/dd/yyyy)				
Check all that apply		☐ Domestic partner ☐ Employee of this business	☐ Disabled ☐ Employee of this business	☐ Disabled ☐ Employee of this business
For the section below, if all members share the same details - only fill out the first column. However, if there are differences, fill out the other respective columns. Please note: PO Boxes do not count as a valid address.				
Residential address, line 1				
Residential address, line 2				
City and state				
ZIP code				
County				
Email				
Phone (xxx) xxx - xxxx				
Preferred language (optional)				

On the day your coverage begins, if you or any of your family members will be eligible or covered by Medicare or other coverage fill out the section below.

Eligible for Medicare?	☐ No ☐ Yes If yes, why? ☐ Age ☐ Disability ☐ ESRD Onset date: / /	☐ No ☐ Yes If yes, why? ☐ Age ☐ Disability ☐ ESRD Onset date: / /	☐ No ☐ Yes If yes, why? ☐ Age ☐ Disability ☐ ESRD Onset date: / /	☐ No ☐ Yes If yes, why? ☐ Age ☐ Disability ☐ ESRD Onset date: / /
Medicare coverage Check appropriate box and list effective date (mm/dd/yyy) and Medicare ID number	☐ Part A: / / ☐ Part B: / / ☐ Part C: / / ☐ Part D: / / ID number:	☐ Part A: / / ☐ Part B: / / ☐ Part C: / / ☐ Part D: / / ID number:	☐ Part A: / / ☐ Part B: / / ☐ Part C: / / ☐ Part D: / / ID number:	☐ Part A: / / ☐ Part B: / / ☐ Part C: / / ☐ Part D: / / ID number:
Other health coverage Check appropriate box and list coverage dates (mm/dd/yyyy), carrier name and Policy number	☐ Individual ☐ Group Start date: / / End date: / / Carrier name: Policy number:	☐ Individual ☐ Group Start date: / / End date: / / Carrier name: Policy number:	☐ Individual ☐ Group Start date: / / End date: / / Carrier name: Policy number:	☐ Individual ☐ Group Start date: / / End date: / / Carrier name: Policy number:

Section D: Choose your plan

Not all plans listed may be available - check with your employer for more 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 E: Terms, conditions, and authorizations

Please read this section carefully before signing the application:

Eligible Employee means:
An active employee of the Employer who works the number of hours per week to be eligible for benefits as defined by the Employer, who meets the definition of "employee" under California State and Federal laws, and approved by Oscar Health Plan of California ("Oscar") as of the effective date. Employment must be verifiable from state or federal wage tax reports;
• An employee, as defined above, who enters into employment after the coverage effective date and who completes the group imposed waiting period for eligibility (if any) and applies for coverage within 30 days;
• Any other class of persons identified by the Employer, provided that written approval of their eligibility is obtained from the Company(ies); or
• An employee, who is eligible for continued coverage under California State or Federal laws.

Eligible Dependent means:
Your spouse, or child age 26 or younger, including a newborn, natural child, or a child placed with You for adoption, a stepchild or any other child for whom You have legal guardianship or court ordered custody. Coverage for children will end on the last day of the month in which the children reach age 26.
• An unmarried child (at any age during initial or continued enrollment), who cannot support himself or herself because of mental retardation, mental illness, or physical incapacity that began prior to the child reaching the age limit for coverage. Coverage may be obtained for the child who is beyond the age limit at the initial enrollment if You provide proof of handicap and dependence at the time of enrollment. You may be asked to provide a physician's certification (HAC 506) of the dependent's condition.
• Dependents eligible for continued coverage under California State or Federal laws.

W-9 Certification:
As part of the W-9 Certification required by the Internal Revenue Service (IRS), I certify that the Social Security number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me) and I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the IRS that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding and I am a U.S. citizen or other U.S. person.

In signing this, I represent that:
• I am an Eligible Employee (as defined above), and I am requesting coverage for myself and all Eligible Dependents (as defined above) listed and authorize my Employer to deduct any required contributions for this insurance from my earnings.
• I understand all benefits are subject to conditions stated in the Group Contract and coverage document.
• I have read or have had read to me the completed application, and I realize any false statement or misrepresentation in the application may result in loss of coverage.

Please read this section carefully before signing the application:

Eligible Employee means:
An active employee of the Employer who works the number of hours per week to be eligible for benefits as defined by the Employer, who meets the definition of "employee" under California State and Federal laws, and approved by Oscar Health Plan of California ("Oscar") as of the effective date. Employment must be verifiable from state or federal wage tax reports;
• An employee, as defined above, who enters into employment after the coverage effective date and who completes the group imposed waiting period for eligibility (if any) and applies for coverage within 30 days;
• Any other class of persons identified by the Employer, provided that written approval of their eligibility is obtained from the Company(ies); or
• An employee, who is eligible for continued coverage under California State or Federal laws.

Applicant signature	Printed name	Date (mm/dd/yyyy)
Sign here ×		

Note: Oscar reserves the right to collect and review supporting documentation.

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.

λληνικά (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, ໂດຍບໍ່ເສັ້ງຄ່າ, 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.