NONGROUP ENROLLMENT/CHANGE REQUEST

oscar

A. Type of Activity – to be completed by enrollee *Refer to instructions on page 5 before completing this form. Print clearly.*

	Activity – Check all that apply	Date of Event	Reason
ADD	☐ Enrollment of a new Member ☐ Add Spouse/Civil Union ☐ Partner Add Domestic Partner ☐ Add Dependent Child	_____/_____/_____ _____/_____/_____ _____/_____/_____ _____/_____/_____	_____ _____ _____ _____
REMOVE	☐ Remove Subscriber ☐ Remove Spouse/Civil Union Partner ☐ Remove Domestic Partner ☐ Remove Dependent Child	_____/_____/_____ _____/_____/_____ _____/_____/_____ _____/_____/_____	_____ _____ _____ _____
OTHER CHANGE	☐ Name Change ☐ Change Plan ☐ Special Enrollment Period (due to a Triggering Event*) ☐ Other **See list of Triggering Events in Instructions*	_____/_____/_____ _____/_____/_____ _____/_____/_____ _____/_____/_____	_____ _____ _____ _____

B. Member Information

Name (Last, First, MI):

SSN:

Birthdate (mm/dd/yyyy)

☐ Male ☐ Female

Email:
By providing an email address you consent to receive information, including the policy, by electronic means.

Are you a resident of New Jersey? ☐ Yes ☐ No

Do you maintain a home in any other state or country? ☐ Yes ☐ No *If yes:*
Name of State/Country:_____ Number of months you live there each year: _____

ADDRESS INFORMATION

Primary Residence:
Street/Apt:_____
Street/Apt:_____
City:_____ State:_____
Zip Code: _____
Phone: (_____)_____

Other Residence:
Street/Apt:_____
Street/Apt:_____
City:_____ State:_____
Zip Code: _____
Phone: (_____)_____

Your billing address: ☐ Primary residence ☐ Other residence ☐ P.O. Box or Other *(specify)*:

☐ Add ☐ Remove ☐ Other Change ☐ Continue If *a name change, indicate prior name:*

Are you eligible for Medicare? ☐ Yes ☐ No Are you covered under Medicare Parts A or B? ☐ Yes ☐ No Please note: If you are eligible for Medicare, the individual policy will coordinate as secondary payor to what Medicare paid or would have paid. Individual policies do not operate as Medicare supplement policies.	Are you covered under any health coverage? ☐ Yes ☐ No If yes, why are you applying for individual coverage? _____

C. Plan Option – *Please check only one. All plans include pediatric dental.*

☐ Oscar Classic Bronze
Deductible: $3,000
Out-of-pocket max: $7,500

☐ Oscar Classic Gold Option 1
Deductible: $2,400
Out-of-pocket max: $2,500

☐ Oscar Classic Silver
Deductible: $2,500
Out-of-pocket max: $7,500

☐ Oscar Saver Silver
Deductible: $2,500
Out-of-pocket max: $6,650

☐ Oscar Simple Secure
Deductible: $7,900
Out-of-pocket max: $7,900

☐ Oscar Classic Gold Option 2
Deductible: $1,500
Out-of-pocket max: $6,000

D. Other Individuals Covered – Identify *individuals other than yourself for whom you are adding/changing/removing coverage. Attach additional pages if necessary, dated and signed by you. Attach proof of disability.*

1. Spouse/Domestic Partner/Civil Union Partner	**2. Child**	**3. Child**	**4. Child**
☐ Add ☐ Remove ☐ Other	☐ Add ☐ Remove ☐ Other	☐ Add ☐ Remove ☐ Other	☐ Add ☐ Remove ☐ Other
Name (last, first, MI) L:_____ F: _____ MI: _____	Name (last, first, MI) L:_____ F: _____ MI: _____	Name (last, first, MI) L:_____ F: _____ MI: _____	Name (last, first, MI) L:_____ F: _____ MI: _____
Birthdate (mm/dd/yyyy):	Birthdate (mm/dd/yyyy):	Birthdate (mm/dd/yyyy):	Birthdate (mm/dd/yyyy):
☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
Social Security Number:	Social Security Number:	Social Security Number:	Social Security Number:

Eligible for Medicare? ☐ Yes ☐ No Covered under Medicare Parts A or B? ☐ Yes ☐ No Covered under any health coverage? ☐ Yes ☐ No	Eligible for Medicare? ☐ Yes ☐ No Covered under Medicare Parts A or B? ☐ Yes ☐ No Covered under any health coverage? ☐ Yes ☐ No	Eligible for Medicare? ☐ Yes ☐ No Covered under Medicare Parts A or B? ☐ Yes ☐ No Covered under any health coverage? ☐ Yes ☐ No	Eligible for Medicare? ☐ Yes ☐ No Covered under Medicare Parts A or B? ☐ Yes ☐ No Covered under any health coverage? ☐ Yes ☐ No _____
If last name is different from member's, please explain: _____	If last name is different from member's, please explain: _____	If last name is different from member's, please explain: _____	If last name is different from member's, please explain: _____
Home address same as member's? ☐ Yes ☐ No *If NO, complete Section E*	Home address same as member's? ☐ Yes ☐ No *If NO, complete Section F*	Home address same as member's? ☐ ☒ Yes No *If NO, complete Section F*	Home address same as member's? ☐ Yes ☐ No *If NO, complete Section F*

E. Additional Spouse/Domestic Partner/Civil Union Partner Information – *If not applicable, please mark as "NA."*	
a. Street/Apt:_____ Street/Apt:_____ City, State, Zip Code:	b. Please explain why the address is different: _____ _____

F. Additional Child Information – *Provide information below about children listed in Section D, if they have a different address. If multiple children are at an address, you may list them together. Attach additional pages as necessary, signed and dated.*

Name(s):_____
Street/Apt:_____
Street/Apt:_____
City, State, Zip Code: _____
Reason:_____

Name(s):_____
Street/Apt:_____
Street/Apt:_____
City, State, Zip Code:_____
Reason:_____

G. Race/Ethnicity – *Response is appreciated but NOT required!*	*Choose a category that most closely describes you:* ☐ American Indian or Alaskan Native ☐ Black, not of Hispanic origin ☐ Hispanic ☐ Asian or Pacific Islander ☐ White, not of Hispanic origin
H. Payment Information – *indicate how you would like to make payment. Note all premiums billed monthly.*	☐ Check ☐ Money Order Electronic Payment Methods ☐ Automatic Bank Draft ☐ Debit Card To authorize electronic payments (automatic bank draft or debit card) please call 1-855-672-2755 or visit us at http://www.hioscar.com
I. Member's Signature	I represent that all the information supplied in this application is true and complete. I hereby agree to the Conditions of Enrollment set forth in this Enrollment/Change Request form Signature: Date:
J. Broker/General Agent Signature	Signature of Preparer | Date / / | NJ Producer License # General Agent | Agent ID #

INSTRUCTIONS AND ELIGIBILITY REQUIREMENTS

Instructions

- ☆ Except for section G, you must complete sections A through I, and sign and date this form, as well as any additional pages you may need to submit with it to provide further requested information.
- ☆ 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, describe this in "Other Change" in Section A, and attach proof of disability.
- ☆ If you are applying to add a spouse, civil union partner, domestic partner, or child please check the applicable box in the "Add" section in A **and** identify the applicable triggering event in the reason section "Other Change" section in A.
- ☆ Eligible for Medicare means the person satisfies the requirements for Medicare but has not yet enrolled for Medicare. Covered under Medicare Parts A or B mean you have Medicare and CANNOT enroll for an individual plan.
- ☆ IF YOU HAVE ANY QUESTIONS concerning the benefits and services provided by or excluded under this policy, contact a member services representative at 1-855-672-2755 before signing this form.
- ☆ KEEP A COPY OF THIS COMPLETED APPLICATION!
- ☆ A temporary ID card can be found at hioscar.com or by calling member services at 1-800-672-2755
- ☆ Triggering Events:
  1. loss of eligibility for minimum essential coverage but not if lost due to non-payment of premium
  2. dependent attained age 26 or 31 and lost coverage
  3. Marketplace changed your subsidy determination
  4. New dependent due to marriage, birth, adoption or placement for adoption, placement in foster care
  5. Gained access to New Jersey plans as a result of permanent move to New Jersey
  6. Child support order or other court order requiring coverage

  Please note: You must provide evidence of the triggering event with your Enrollment form.

Eligibility

A. Eligibility requirements are set forth under the Individual Health Coverage Reform Act of 1992, P.L. 1992, c. 161 (N.J.S.A. 17B:27A-2 et seq.).
B. You MUST be a New Jersey resident which means your primary residence is in New Jersey
C. You must not be enrolled for Medicare Parts A or B.
D. 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 uninsured or who are covered under another individual plan, or who are covered under a group health plan, group health benefits plan, a governmental plan, a church plan. Your application must be received during the designated Annual Open Enrollment Period. The effective date of coverage applied for by December 31will be January 1 of the immediately following year. *If* the designated Annual Open Enrollment Period extends beyond December, the effective date of coverage will be the first [or fifteenth] of the month following the date of the application.

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 [or fifteenth] 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.

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.

CONDITIONS OF ENROLLMENT -- [APPLICANT] ACKNOWLEDGEMENTS AND AGREEMENTS

On behalf of myself and the dependents listed in this Enrollment/Change Request form, I acknowledge that:

1. I authorize any physician or medical professional, hospital, clinic or other medical care institution, carrier, consumer reporting agency, and any employer to give Oscar Garden State Insurance Corporation, or any consumer reporting agency acting on behalf of Oscar Garden State Insurance Corporation, information pertaining to employment, other health coverage, and medical advice, treatment or supplies for any physical or mental condition relevant to me or a minor dependent applying for coverage. I agree that this authorization shall be valid for 30 months from the date I sign this Enrollment/Change Request form, unless revoked at an earlier date.
2. I agree that, if I revoke this authorization before it expires, such revocation shall not affect any action that Oscar Garden State Insurance Corporation has taken in reliance on the authorization.
3. I understand I may receive a copy of this authorization if I request one.
4. I agree Oscar Garden State Insurance Corporation will provide coverage in accordance with the terms of the contract for the individual policy.
5. I understand that my enrollment and the enrollment of my listed dependents in Oscar Garden State Insurance Corporation's individual policy is subject to acceptance by Oscar Garden State Insurance Corporation's.
6. I agree that the provision of coverage and benefits is contingent upon payment of premiums and may be terminated in accordance with the terms of the individual policy if premiums are not paid timely.

MISREPRESENTATIONS

Any person who includes any false or misleading information on a Nongroup Enrollment/Change Request Form is subject to criminal and civil penalties.