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 Member ☐ 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. Applicant 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.*

☐ Oscar Bronze Classic
Deductible: $3,000
Out-of-pocket max: $9,100

☐ Oscar Silver Classic
Deductible: $2,500
Out-of-pocket max: $8,900

☐ Oscar Silver Simple
Deductible: $2,500
Out-of-pocket max: $7,200

☐ Oscar Silver Simple PCP Saver
Deductible: $2,500
Out-of-pocket max: $8,900

☐ Oscar Secure
Deductible: $9,100
Out-of-pocket max: $9,100

☐ Oscar Silver Classic Saver Plus
Deductible: $0
Rx Deductible: $750
Out-of-pocket max: $9,100

☐ Oscar Gold Classic PCP Saver
Deductible: $1,750
Out-of-pocket max: $7,000

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. Applicant'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 # or ☐ NPN
	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 www.hioscar.com or by calling member services at 1-800-672-2755.
- ☆ Triggering Events:

1. Loss of eligibility for minimum essential coverage or medically needy coverage but not if lost due to non-payment of premium
2. Voluntary or involuntary non-renewal of a non-calendar year plan
3. Loss of pregnancy-related coverage or access to health care services through coverage for your unborn child
4. Dependent attained age 26 or 31 and lost coverage
5. Marketplace determination that you are no longer eligible for a subsidy
6. Marriage (at least one spouse must have had coverage for at least 1 day within the prior 60 days)
7. Confirmation of pregnancy by a health care provider
8. Birth, adoption, or placement for adoption, placement in foster care or gaining a child through a child support order or other court order, but only you and the new dependent are eligible for the special enrollment.
9. Gained access to New Jersey plans as a result of permanent move to New Jersey (must have had coverage at least 1 day within the prior 60 days)
10. Application to NJ FamilyCare submitted during open enrollment period or during a Special Enrollment period is found ineligible
11. Domestic abuse or spousal abandonment necessitating coverage apart from the perpetrator
12. Erroneous enrollment or non-enrollment due to error, misrepresentation, misconduct or inaction of entity providing enrollment assistance or a carrier's violation of a material provision of the plan in relation to a covered person.
13. Your effective date under a health reimbursement arrangement know as either an ICHRA or QSEHRA

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

Eligibility

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.).

A. You MUST be a New Jersey resident which means your primary residence is in New Jersey
B. You must not be enrolled for Medicare Parts A or B.
C. 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 notice that you qualify for an exemption with an exemption certificate number (ECN) from the Marketplace. Attach a copy of that notice 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. The Open Enrollment Period begins November 1, 2022 and continues until January 31, 2023. Your application must be signed, dated and mailed during the Annual Open Enrollment Period. The effective date of coverage applied for by December 31, 2022 will be January 1, 2023. The effective date of coverage applied for by January 31, 2023 will be February 1, 2023.

A **Special Enrollment Period** that lasts for 60 days follows the listed Triggering Events. 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.

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.
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.

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, including sex stereotypes and gender identity. Coverage for medically necessary health services is made available on the same terms for all individuals, regardless of sex assigned at birth, gender identity, or recorded gender. Oscar will not deny or limit coverage to any health service based on the fact that an individual's sex assigned at birth, gender identity, or recorded gender is different from the one to which such health service is ordinarily available. Oscar will not deny or limit coverage for a specific health service related to gender transition if such denial or limitation results in discriminating against a transgender individual.

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 at all times 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:

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

All other Members: Oscar Insurance, Attention: Grievances, PO Box 52146, Phoenix, AZ 85072

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 em ail. 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.

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 סערוויסעס 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 لك بالمجان. اتصل برقم 1–855–RACSO–558.

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 .بگیرید ت 1-855–OSCAR-55.

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

ગુજરાતી (Gujarati): સૂચના: 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): ถ้ า คุ ณพู ดภา ษาไทยคุณสามารถใช้ บริการช่ วยเหลือท างภาษาได้ ฟรี 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.

Navajo Diné Bizaad: Díí baa akó nínízin: Díí saad bee yáníłti'go **Diné Bizaad**, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih **1-855-OSCAR-55** (TTY: 711.)

Srpsko-hrvatski (Serbo-Croatian): OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-855-OSCAR-55