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New York 2021 Business Enrollment Form

Instructions

The attached forms should be completed with the assistance of your authorized Broker or Oscar Enrollment Guide. 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 Enrollment Guide.

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.

New York Business Enrollment Form
This can be completed online in the Oscar enrollment portal.

New York Employee Enrollment application(s)
One application should be completed for each enrolling employee or COBRA/Continuation of benefits 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)
One form is needed for each employee waiving or refusing coverage. Waivers may be completed online in the Oscar enrollment portal.

Payroll verification through appropriate tax documentation (required for all groups)
NYS 45 is required for all enrolling groups, unless there are seven (7) or more enrolling eligible employees. If the NYS 45 is not available, the most recent payroll document will suffice. All payroll verifications must be scanned and uploaded to the portal.

ACH Authorization Form
This 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 Insurance Corporation
P.O. Box 415841
Boston, MA 02241 - 5841

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Section A: Business information

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

Business classification

☐ S Corp ☐ Non-Profit ☐ LLP

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

Was this business established within the last year?

☐ No ☐ Yes 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)

First name	Last name		Job title
Email	Phone	Ext.	Fax (optional)

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		
City	State	ZIP code

Additional business contact (optional)

First name	Last name		Job title
Email	Phone	Ext.	Fax (optional)

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		
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	Number of employees	Employees enrolling

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

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.

Writing payable/sub-agent/producer/broker		**Second writing payable/sub-agent/producer/broker**	
First name	Last name	First name	Last 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)

General agent/producer/broker use only

General agency name

General agency representatives

General agency representative name	Email

Section A.4: Prior carrier coverage (required)

If this plan is a total replacement of any existing group plans, please list the carrier and relevant information below:

Total replacement	Prior carrier name	Start date (mm/dd/yyyy)	End date (mm/dd/yyyy)
Is Oscar completely replacing this carrier? If yes, please explain:			
Is Oscar completely replacing this carrier? If yes, please explain:			

Section B: Eligibility and enrollment[1]

Preferred effective date of coverage (mm/dd/yyyy)? Must be 1st or 15th of a future month.
(Applications must be submitted online 24 hours before the requested date).

Will this group only be offering coverage to a class or classes (also known as carve outs)? ☐ No ☐ Yes

Total number of full-time equivalent (FTE) employees[2] over the previous calendar year? (including employed owners/officers and part-time employees; excluding COBRA)

Total number of eligible employees?
(minimum 20 hours per week)

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

How many eligible employees will be submitting valid waivers?
At least 51% of all eligible employees must participate in the policy. Refer to Underwriting Guidelines for more detail.

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

If yes to the question above, what is the number of employees enrolling in another carrier?

Did your business have 20 or more total employees during at least 50% of the working days in the previous calendar year?[3]
(If yes, your business is subject to COBRA and New York State Continuation. If no, your business is subject to New York State Continuation of Coverage.) ☐ No ☐ Yes

Will (or did) your business have at least 20 full-time and part-time employees for at least 20 weeks in the current or last calendar year?[4] ☐ No ☐ Yes

[1] Oscar requires certain forms of proof to establish eligibility. Please contact us at 1-855-672-2784 for our details regarding eligibility categories and required forms of proof. At least one (1) eligible, active, full-time employee must be enrolled (excluding officers/owners). Oscar reserves the right to request additional documentation to confirm number of hours worked and other relevant information when verifying group size/eligibility for participation.

[2] 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. [3] Use the FTE employee counting method described above.

[4] Include all full-time employees, part-time employees, seasonal employees, temporary employees, union workers, owners, partners and officers. Exclude self-employed persons, independent contractors (1099), directors and leased employees. Unlike the FTE counting method above, here, each included employee counts as one.

Section C: Employee classes and medical coverage selection

Do you wish to offer coverage for Domestic Partners? ☐ No ☐ Yes

Complete the following section(s) to create employee classes. Remember - at least one class is required, and classes without one enrolled employee are not allowed. If you have any questions, please refer to Underwriting Guidelines or contact us at business@hioscar.com.

Section C.1: Employee class information (complete for each class you would like to create for this business)

Enter class name:

If you're offering coverage to a specific class of employees, select one of the following class definitions. Remember - employees who work less than 20 hours per week are not eligible.

☐ Geographic site of employment
☐ Earnings method of compensation (e.g., hourly vs salaried)
☐ Hours worked per week
☐ Occupational duties
☐ Date of hire or length of service
☐ Membership in a union
☐ All employees
☐ Other

Select waiting period for new employees in this class:

☐ No waiting period: coverage begins on date of hire
☐ 1st of month after the date of hire
☐ 1st of month 30 days after the date of hire
☐ 1st of month 60 days after the date of hire
☐ 30 days after the date of hire
☐ 60 days after the date of hire
☐ 90 days after the date of hire

Choose the employer medical premium monthly contribution amount for this class's employees:

_____ % or $ _____ ☐ No contribution

Choose the employer medical premium monthly contribution amount for this class's employee dependents (optional):

_____ % or $ _____ ☐ No contribution

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 $).

Do you wish to offer Dependent child coverage from age 26 through age 29? ☐ No ☐ Yes

All plans below include pediatric dental coverage.

Select plans to offer this class for 2020 (for full plan details, visit hioscar.com/forms):

☐ Circle Bronze $4500
☐ Circle Bronze $5400 HSA
☐ Circle Bronze $7300
☐ Circle Silver $0
☐ Circle Silver $3000
☐ Circle Silver $3250 HSA
☐ Circle Silver $5000
☐ Circle Gold $0
☐ Circle Gold $1250
☐ Circle Gold $2000
☐ Circle Gold $1000
☐ Circle Platinum $0 Option 1
☐ Circle Platinum $0 Option 2

If you would like to add additional classes, print copies of this page and attach it to your application.

Section D: General agreement

Please read this section carefully before signing the application:

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 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.

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 Sign here **X**	Printed name and title	Date (mm/dd/yyyy)
Accepted by Oscar authorized representative	Printed name	Date (mm/dd/yyyy)