oscar

Business Enrollment Form - California 2021

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.

Requested Effective Date - 1st or 15th of any future month (mm/dd/yyyy)

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 2021**
This can be completed online in the Oscar enrollment portal.

☐ **Payroll verification through appropriate tax documentation**
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 66550
Los Angeles, CA 90066

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)		Mailing address line 2	
City	State	ZIP code	County
Federal Tax ID number	SIC code (optional)	Nature of business	State License number (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 (required)

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 [3]

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.
[3] For a definition of eligible employee, please refer to Oscar's Underwriting Guidelines.

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 employee's. 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):

☐ Oscar Bronze $8,550 EPO Option 1

☐ Oscar Bronze $8,550 EPO Option 2

☐ Oscar Bronze 60 HDHP EPO $7,000/0% + Child Dental

☐ Oscar Bronze 60 EPO $6,300/$65 + Child Dental

☐ Oscar Silver $0 EPO

☐ Oscar Silver $2,000 EPO

☐ Oscar Silver 70 EPO $1,500/$50 + Child Dental

☐ Oscar Silver 70 EPO $2,250/$55 + Child Dental

☐ Oscar Silver 70 HDHP EPO $2,500/20% + Child Dental

☐ Oscar Gold $500 EPO

☐ Oscar Gold $1,000 EPO

☐ Oscar Gold $2,000 EPO

☐ Oscar Gold 80 EPO $0/$30 + Child Dental

☐ Oscar Gold 80 EPO $250/$35 + Child Dental

☐ Oscar Platinum $0 EPO Option 1

☐ Oscar Platinum $0 EPO Option 2

☐ Oscar Platinum 90 EPO $0/$20 + Child Dental

Section D: General agreement

Please read this section carefully before signing the application:

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. 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. We understand that if we have committed fraud or made any intentional misrepresentation of material fact in conjunction with this application, within the first 24 months of issuance of coverage, Oscar may cancel coverage; adjust premium amounts; or, following notice, rescind the contract.

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 ×		