# oscar Individual Enrollment Application/Change **Form California**

## Choose your plan

- (●) Oscar Simple Bronze EPO
- ( ) Oscar Simple Silver EPO
- ( ) Oscar Simple Gold EPO
- ( ) Oscar Simple Platinum EPO
- ( ) Oscar Simple+ Silver EPO
- ( ) Oscar Simple+ Gold EPO
- ( ) Oscar Simple+ Platinum EPO
- ( ) Oscar Minimum Coverage EPO
- ( ) Oscar Bronze 60 EPO
- ( ) Oscar Silver 70 EPO
- ( ) Oscar Gold 80 EPO
- ( ) Oscar Platinum 90 EPO

Oscar ID (if changing an existing plan)

## Who are you buying insurance for?

- ( ) Individual
- ( ) Individual & Spouse
- ( ) Parent & Child(ren)
- ( ) Family

## Type of Activity

- ☐ Add dependent
- ☐ Remove dependent
- ☐ Change benefit plan
- ☐ Marital status change
- ☐ Update name and/or address
- ☐ Special enrollment period (following a triggering event, see list in instructions)

Reason

Date of event ____ ____ _____

## Tell us about yourself and your dependents

*If you have a disabled dependent over age 26, please call us at 1-855-OSCAR-55 to request a disabled dependent form

| | Name (First, Middle Initial, Last) | Is dependent disabled?* | Gender (M/F) | Social Security No. | Date of Birth (MM/DD/YYYY) | Enrolled in Medicare? |
|---|---|---|---|---|---|---|
| Applicant | | | | | | ☐ |
| Spouse | | | | | | ☐ |
| Child dependent(s) | | ☐ | | | | ☐ |
| | | ☐ | | | | ☐ |
| | | ☐ | | | | ☐ |
| | | ☐ | | | | ☐ |
| | | ☐ | | | | ☐ |
| | | ☐ | | | | ☐ |

## Just a few more questions

Home address | Apt # | City | County | State | Zip code

Home phone | Cell phone | Email address

Primary language (if other than English) | Martial Status ( ) Single ( ) Married ( ) Domestic Partner

If your mailing address is different than your home address, please enter it below

Name | Address | Apt # | City | County | State | Zip code

## GA / Broker info (if applicable)

| | Name | License number | Agency name | Phone | Email |
|---|---|---|---|---|---|
| GA | | | | | |
| Broker | Kevin Knauss | 0H12644 | | 916-521-7216 | kevin@insuremeke |
| Co-broker | | | | | |

## Please Read the Following Terms & Conditions Carefully

It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

**NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.**

Signature

Date

By typing your name, you are signing this Agreement electronically and consenting to its terms & conditions. You agree your electronic signature is the legal equivalent of your manual signature on this Agreement. Note that Oscar will use either your qualifying event date or date the application was submitted to Oscar to determine your effective date of coverage. We will not use the signature date on this application.

Please send completed form to

## Instructions for making changes to your contract

1. Write the current contract holder's information (name, address, date of birth, gender, SSN, phone, and email).
   *Exception:* if you are making a change to the contract holder's name or address, please write the new name or address (see below for further instructions).
2. Enter current Oscar member ID.
3. Follow the instructions below for the specific change you want to make.
4. Enter the month you want the change to take effect in the "Effective Date of Coverage" field.

**Adding a dependent**

- Check the "Add Dependent" box.
- Indicate the date of qualifying event:
  - Date of birth or adoption (Congrats!).
  - Date other health insurance coverage was lost.
- Enter the new dependent's information in the eligible family members section.

**Removing a dependent**

- Check the "Remove Dependent" box.
- Enter the information of the dependent being removed in the eligible family members section.

**Updating name and/or address**

- Check the "Update Name and/or Address" box.
- If changing the contract holder's name and/or address:
  Enter the new name/address in the appropriate fields at the top of the form.
  Please include all other identifying information as well (date of birth, SSN, telephone number, email address).
- If changing the name of a dependent: Enter the new name of the dependent in the appropriate field under the eligible family members section. Please include the other identifying information as well (gender, SSN, and date of birth).

**Changing benefit plan**

- Check the "Change Benefit Plan" box.
- Enter the contract holder's information in the appropriate fields at the top of the form.
- In the choose your plan section at the top, indicate the plan you'd like to switch into. Please be aware that if your contract is an Individual & Spouse, Parent & Child(ren), or Family, the change will be applied to everyone on the contract.

**Marital status change**

- Check the "Marital Status Change" box.
- Indicate the date on which your marital status changed.
- If you're including a new family member (spouse or domestic partner), check the "Add Dependent" box and enter the new family member's information in the eligible family members section.
- If you're removing an existing family member, check the "Remove Dependent" box and enter the information of the person being removed
  in the eligible family members section.

## Eligibility

1. You must not be enrolled in Medicare.
2. You must reside in the Oscar service area.

## 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 and lost coverage
3. Marketplace changed your subsidy determination
4. Gain a dependent or becomes a dependent through marriage, birth, adoption or placement for adoption, or through a Qualified Medical Child Support Order or court order
5. Gained access to California plans as a result of permanent move to California
6. No longer incarcerated
7. Became lawfully present
8. Gained status as an Indian
9. Enrollment or non-enrollment in another qualified health plan was unintentional, inadvertent, or erroneous and was the result of the error, misrepresentation, or agent of a health plan or the Exchange
10. Can demonstrate another qualified health plan in which prospective member was enrolled substantially violated a material provision of its contract
11. He or she is a member of the reserve forces of the United States military returning from active duty or a member of the California National Guard returning from active duty service under Title 32 of the United States Code.

For a list of qualifying event documentation, please see **hioscar.com/brokers/resources**