

New York 2018/2019 Business Enrollment Form

Instructions

This is an application for enrollment that allows NY small groups to enroll in coverage for 2018 and continue coverage in 2019 on new plans and/or networks. We want to make this process as smooth and as simple as possible for employers, members, brokers and beyond. Just complete the following steps to ensure a complete and simple application:

- Complete this 'New York 2018/2019 Business Enrollment Form' that includes 2018 and 2019 plan selections
- (optional) Complete a NY ACH Authorization form that allows us to autodebit the group's payments electronically
- Complete a 'New York 2018/2019 Employee Enrollment Form' for all enrolling employees that includes 2018 and 2019 plan selections

The process for these enrollments will be as follows:

- All enrollment applications must be submitted through Oscar's online portal by Midnight on October 31, 2018 for a November 1, 2018 effective date. All applications must be submitted by Midnight on November 30, 2018 for a December 1, 2018 effective date.
- Once Oscar receives the group's payment, the policy will be effectuated and 2018 member IDs will be shipped out (ACH autopay will make this process fast and easy).
- Coverage will start 11/1/2018 or 12/1/2018 with all members enrolled in 2018 Oscar plans
- As long as the policy is effectuated, 2019 coverage will begin on 1/1/2019. Members will receive new ID cards for their 2019 plans.

Agreement and signature

Please read this section carefully before signing the application:

By signing the document below, I acknowledge that my company will be enrolled in two sets of health insurance plans with the Oscar Insurance Corporation -- one set of plans for November or December 2018, and a second set for the full calendar year of January-December 2019. These plans will be selected using the form below. Employees will be able to choose both plans at once and new coverage will begin in 2019.

Oscar Insurance Corporation will be offering two networks in 2019 -- Oscar Circle (which is similar to our 2018 network) and Oscar Circle Plus (which includes additional providers and out of area coverage). In order to facilitate transition to this new network, during 2018 Oscar is offering an Enhanced Transitional Care Rider at no additional cost. By submitting this application, I acknowledge that I am electing to offer to my employees the Enhanced Transitional Care Rider. As a result, employees will have access for a period of sixty days to out-of-network providers who agree to accept Oscar's reimbursement and terms. After the period of sixty days has expired, employees will have access only to those providers in the Oscar Circle or Circle Plus network (depending on the plan in which they enrolled).

Lastly, I acknowledge that amounts paid by the employees toward their 2018 deductibles and out-of-pocket maximums will not count toward meeting their 2019 deductibles and out-of-pocket maximums. I also acknowledge that premium will change in 2019.

Business administrator signature X	Printed name and company name	Date (mm/dd/yyyy)
Broker signature X	Broker name and agency (if applicable)	Date (mm/dd/yyyy)

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.

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 2018/2019 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. 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

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 <input type="checkbox"/> S Corp <input type="checkbox"/> Non-Profit <input type="checkbox"/> LLP <input type="checkbox"/> C Corp <input type="checkbox"/> Partnership <input type="checkbox"/> LLC <input type="checkbox"/> Other (please explain):			
Was this business established within the last year? <input type="checkbox"/> No <input type="checkbox"/> 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
Is this person also the billing contact? <input type="checkbox"/> No <input type="checkbox"/> Yes Is their mailing address different then the business's address? <input type="checkbox"/> No <input type="checkbox"/> 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
Is this person also the billing contact? <input type="checkbox"/> No <input type="checkbox"/> Yes Is their mailing address different then the business's address? <input type="checkbox"/> No <input type="checkbox"/> 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)

- 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.
- 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.
- 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.
- 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.
- 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.
- 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

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 enrollment¹

Preferred effective date of coverage (mm/dd/yyyy)? Must be 11/01/2018 or 12/01/2018.

(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) employees² over the previous calendar year? (including employed owners/officers and part-time employees; excluding COBRA)

Total number of eligible employees?

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

Our 2019 networks will be named Circle and Circle Plus. The 2019 Circle network is similar to our existing 2018 network. The 2019 Circle Plus network will include additional providers and out of area coverage (OOA). OOA is automatically part of all Oscar Circle Plus plans and cannot be added to Oscar Circle plans.

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.

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Geographic site of employment | <input type="checkbox"/> Hours worked per week | <input type="checkbox"/> Date of hire or length of service | <input type="checkbox"/> All Employees |
| <input type="checkbox"/> Earnings method of compensation (e.g., hourly vs salaried) | <input type="checkbox"/> Occupational duties | <input type="checkbox"/> Membership in a union | <input type="checkbox"/> (Other) |

Select waiting period for new employees in this class:

<input type="checkbox"/> No waiting period: coverage begins on date of hire		
<input type="checkbox"/> 1st of month after the date of hire	<input type="checkbox"/> 1st of month 30 days after the date of hire	<input type="checkbox"/> 1st of month 60 days after the date of hire
<input type="checkbox"/> 30 days after the date of hire	<input type="checkbox"/> 60 days after the date of hire	<input type="checkbox"/> 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 \$).

Section C.2: 2018 plan selections (to be effective from 11/01/2018 or 12/01/2018 - 12/31/2018)

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 (visit hioscar.com/forms for full plan details). In choosing your plan for 2018, please be reminded that amounts paid by the employees toward their 2018 deductibles and out-of-pocket maximums will not count toward meeting their 2019 deductibles and out-of-pocket maximums.

- | | | | | |
|--|--|--|--|---|
| <input type="checkbox"/> Classic Platinum \$0 \$3000 10% | <input type="checkbox"/> Classic Gold \$0 | <input type="checkbox"/> Classic Silver \$3000 | <input type="checkbox"/> Simple Gold | <input type="checkbox"/> Backup Gold |
| <input type="checkbox"/> Classic Platinum \$0 \$3000 | <input type="checkbox"/> Classic Gold \$500 | <input type="checkbox"/> Classic Silver \$3500 | <input type="checkbox"/> Simple Silver | <input type="checkbox"/> Backup Silver \$3000 |
| <input type="checkbox"/> Classic Platinum \$0 \$2000 | <input type="checkbox"/> Classic Gold \$1000 | <input type="checkbox"/> Classic Silver \$4000 | <input type="checkbox"/> Simple Bronze | <input type="checkbox"/> Backup Silver \$5000 |
| | <input type="checkbox"/> Classic Gold \$2000 | <input type="checkbox"/> Classic Silver \$4500 | | <input type="checkbox"/> Backup Bronze |
| | | <input type="checkbox"/> Classic Bronze | | |

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

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

Section C.3: 2019 plan selections for this class

All plans below include pediatric dental coverage.

Select plans to offer this class for 2019 (for full plan details, visit hioscar.com/forms):

- | | | | | |
|---|--|--|--|--|
| <input type="checkbox"/> Circle Platinum \$0 | <input type="checkbox"/> Circle Gold \$0 | <input type="checkbox"/> Circle Silver \$0 | <input type="checkbox"/> Circle Bronze \$4000 | <input type="checkbox"/> Circle Silver \$3000 HSA |
| | <input type="checkbox"/> Circle Gold \$750 | <input type="checkbox"/> Circle Silver \$2700 | <input type="checkbox"/> Circle Bronze \$7900 | <input type="checkbox"/> Circle Bronze \$6650 HSA |
| | <input type="checkbox"/> Circle Gold \$1500 | <input type="checkbox"/> Circle Silver \$3500 | | |
| | <input type="checkbox"/> Circle Gold \$2000 | <input type="checkbox"/> Circle Silver \$4500 | | |
| | <input type="checkbox"/> Circle Gold \$5000 | <input type="checkbox"/> Circle Silver \$7900 | | |
|
 | | | | |
| <input type="checkbox"/> Circle Plus Platinum \$0 | <input type="checkbox"/> Circle Plus Gold \$0 | <input type="checkbox"/> Circle Plus Silver \$0 | <input type="checkbox"/> Circle Plus Bronze \$4000 | <input type="checkbox"/> Circle Plus Silver \$3000 HSA |
| | <input type="checkbox"/> Circle Plus Gold \$750 | <input type="checkbox"/> Circle Plus Silver \$2700 | <input type="checkbox"/> Circle Plus Bronze \$7900 | <input type="checkbox"/> Circle Plus Bronze \$6650 HSA |
| | <input type="checkbox"/> Circle Plus Gold \$1500 | <input type="checkbox"/> Circle Plus Silver \$3500 | | |
| | <input type="checkbox"/> Circle Plus Gold \$2000 | <input type="checkbox"/> Circle Plus Silver \$4500 | | |
| | <input type="checkbox"/> Circle Plus Gold \$5000 | <input type="checkbox"/> Circle Plus Silver \$7900 | | |

If you would like to add additional classes, print another copy 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 X	(Sign here)	Printed name and title	Date (mm/dd/yyyy)
Accepted by Oscar authorized representative		Printed name	Date (mm/dd/yyyy)

New York ACH Authorization Form

Section A: Business billing information			
Billing contact (full name)		Business name	
Business billing address (cannot be a P.O. Box)			
City	State	ZIP code	County
Email		Phone	
Section B: ACH account information			
Account type <input type="checkbox"/> Checking <input type="checkbox"/> Savings		10724043331 1234567890 <small>Routing number (9 digits) Account number</small>	
Bank name		Routing number	
Account number		Confirm account number	
Section C: Payment settings			
<input type="checkbox"/> Enroll in auto-pay Have your bill automatically paid each month with the bank account you chose in the section above.		<input type="checkbox"/> Enroll in paperless billing Save paper and have your bill emailed to you and your team each month.	
Section D: General agreement			
<p>I (we) hereby authorize Oscar Health Insurance Corporation and associated entities (Oscar) to initiate entries to my (our) checking/ savings accounts at The Financial Institution listed above, and, if necessary, initiate adjustments for any transactions credited/ debited in error. This authority will remain in effect until Oscar notifies me (us) that this service has been discontinued or Oscar is notified by me (us) in writing to cancel it in such time as to afford Oscar and The Financial Institution a reasonable opportunity to act on it.</p>			
Signature of applicant		Printed name	Date (mm/dd/yyyy)
X <div style="text-align: right; border: 1px solid red; border-radius: 15px; padding: 2px 10px; display: inline-block;">Sign here</div>			