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New Jersey
Application for Small Group Health Benefits Policy

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.

Ensure that all areas requiring a signature and date are complete. The Officer, Partner, Owner and / or Correspondent signing the application must be listed on the New Jersey Small Employer Certification. 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. 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.

- ☐ **2018 New Jersey Application for Small Group Health Benefits Policy**
  This can be completed online in the Oscar enrollment portal and Section 5 (Signature) should be signed, scanned, and uploaded where indicated in the portal.

- ☐ **New Jersey Small Employer certification**
  This entire form is required to be signed, scanned, and uploaded to the portal

- ☐ **New Jersey Employee Enrollment application**
  One application should be completed for each employee or COBRA/continuation of benefits recipient enrolling. These applications can be completed entirely online by the employees, or completed on paper and data entered into the online portal.

- ☐ **Small Employer Health Benefits Waiver of Coverage**
  One form is needed for each employee waiving or refusing coverage. These can be completed online.

- ☐ **Payroll verification through appropriate tax documentation, i.e., WR30 (required for groups of five or fewer eligible)**
  WR30 is required for groups of 5 or fewer eligible employees. If WR30 is not available a substitute payroll document such as a K-1, Schedule C and/or 1120 will suffice. All payroll verifications must be scanned and uploaded to the portal.

- ☐ **ACH Authorization Form**
  This is optional but highly encouraged to expedite 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 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 below:

  Oscar Garden State Insurance Corporation
  P.O. Box 419895
  Boston, MA 02241 - 9895

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Preferred effective date of coverage (mm/dd/yyyy)? Must be the 1st or 15th of a future month.

(Note: The Effective Date will be on or after the date Oscar approves the application.)

Section 1: Policyholder information

Policyholder (full legal name of company)	Tax Identification Number
Business address	
City / State / ZIP	
Mailing address (if different than address from above)	
City / State / ZIP	
Telephone / Facsimile / Email address	

Contract information should be provided (check one)

☐ Electronically ☐ Hard copy

Correspondent	Title

Type of organization

☐ Corporation ☐ Partnership ☐ Proprietorship ☐ Other (explain):

Nature of business (specify):	SIC code

Number of full-time employees in your company*	Number of full-time employees to be insured	Class or classes to be excluded

Insurance requested for

☐ Employees Only ☐ Employees and Dependents including Spouse ☐ Employees and Dependents excluding Spouse

→ Should the plan provide coverage for domestic partners as permitted by P.L. 2003, c. 246? ☐ No ☐ Yes

If yes, should the plan provide coverage for coverage of children of a covered domestic partner? ☐ No ☐ Yes

Is the employer subject to the requirements of COBRA? ☐ No ☐ Yes

Is the employer subject to the requirements of Medicare as Secondary Payor Rules for eligibility due to age? ☐ No ☐ Yes

Due to disability? ☐ No ☐ Yes

Orientation period? ☐ No ☐ Yes

*Refer to the New Jersey Small Employer Certification for the definition of a full-time employee.

Waiting period before employees become insured (may not exceed 90 days):

Present employees	☐ No waiting period	☐ One month	☐ Two months	☐ 90 days
New or rehired employees	☐ No waiting period	☐ One month	☐ Two months	☐ 90 days

Period for Annual Employee Open Enrollment Period

What percentage of the premium will the employer pay?

Deposit ($)

Premium paid ☐ Monthly ☐ Automatic checking withdrawal

Affiliates, subsidiaries or branches (Must be included for purposes of participation)

Legal name & location	No. of full-time employees in this company	No. of full-time employees to be insured

Section 2: Specifications for coverage

Please select up to 3 desired health benefits options:

- ☐ Classic Bronze $2,500 EPO
- ☐ Classic Bronze $3,000 EPO
- ☐ Classic Silver $1,500 EPO
- ☐ Classic Silver $2,000 30% EPO
- ☐ Classic Silver $2,000 50% EPO
- ☐ Classic Silver $2,500 30% EPO
- ☐ Classic Silver $2,500 50% EPO
- ☐ Classic Gold $0 $4,500 EPO
- ☐ Classic Gold $0 $5,000 EPO
- ☐ Classic Gold $0 $7,000 EPO
- ☐ Classic Gold $1,000 $5,500 EPO
- ☐ Classic Gold $1,000 $7,000 EPO
- ☐ Classic Gold $1,500 EPO
- ☐ Classic Platinum EPO
- ☐ Classic Platinum 20% EPO
- ☐ Backup Silver $2,000 EPO
- ☐ Backup Silver $2,500 EPO
- ☐ Backup Silver $2,500 $6,000 $7,000 $18,000 PPO

Deductibles and out-of-pocket accumulation periods are on a... ☐ Calendar year ☐ Contract year basis

Section 3: All questions must be answered

1. Is there any Group Health Plan:
   Now in force and to be continued? ☐ No ☐ Yes
   Currently being applied for? ☐ No ☐ Yes

If "Yes", identify the name of the Group Health Plan, give a description of the plan(s) and name of insurance carrier(s):

2. Name of present or prior group carrier

Effective date of prior coverage

Cancellation/termination date

Is the coverage applied for in this application replacing other group insurance? ☐ No ☐ Yes

If "Yes", give reason:

Plan being replaced:

3. Are extended benefits provided in case of termination of health benefits? ☐ No ☐ Yes

To the best of your knowledge are there any current or former employees or their eligible dependents whose health insurance is being continued? ☐ No ☐ Yes

Please provide the following information for each current/former employee or dependent on health continuations.

Name of employee / dependent	Date of birth	Type of continuation State/Federal/Extended Benefits	Reason for termination Disability/Other	Continuation dates Start	End

(If additional space is needed, attach a separate sheet, signed and dated.)

To the best of your knowledge:
Are any employees or dependents presently incapacitated? ☐ No ☐ Yes
Are any dependent children incapable of self-support due to a physical or mental disability? ☐ No ☐ Yes

Additional space to explain if items in this section were answered "Yes".
Give details including names where appropriate.

Does the employer participate in an arrangement with a Professional Employer Organization? ☐ No ☐ Yes
(Refer to Advisory Bulletin 00-SEH-02 if you need information concerning what constitutes a Professional Employer Organization.)

If yes, is health coverage available as a client of the PEO? ☐ No ☐ Yes

Section 4: Agent/producer information and underwriting group enrollment use

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		Phone	
Email		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 5: Signature

It is understood that, except as provided under applicable regulations, no individual shall become insured while not actively at work on a full-time basis, and only full-time employees are eligible. (Refer to the definition on the New Jersey Employer Certification.) It is further understood that no agent has power on behalf of Oscar to make or modify any request or application for insurance or to bind Oscar by making any promise or representation or by giving or receiving any information.

It is further understood that no insurance will be effective unless and until the application is accepted in writing by Oscar. Final rates will be based on enrollment data as of the Policy effective date. No contract of insurance is to be implied in any way on the basis of the completion and/or submission of this application.

It is understood that I am responsible to provide Oscar with timely and accurate information regarding the date of hire for new employees and that the requested effective date of coverage will properly apply any orientation period and waiting period requirements applicable to my plan. It is further understood that any retroactive termination requests must be limited to those for which no premium or contribution has been paid for the termination period by the employee or dependent whose coverage is to be retroactively terminated.

☐ Please read this statement and check to confirm. I confirm that I have received the Summary of Benefits and Coverage (SBC) documents associated with the plan or plans I selected on this application. I confirm I will provide SBCs to plan participants and beneficiaries as required by federal regulations and guidance related to the distribution of the SBC, including the requiring for timing and delivery.

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Signature of employer	Print name of Officer, Partner or Proprietor
Witness to Signature Sign here x	Signature of Officer, Partner or Proprietor Sign here x .....

Note: If there are any modifications to the statements and answers given in this application (i.e., crossed out, whited-out, erased information), the applicant must attest to the modifications by giving a complete signature in the margin near the modification.