Oscar for Business Enrollment Eligibility Checklist

Let's work together to make sure every group you submit gets approved. Follow the checklist below, and reach out to Broker Support at **brokers@hioscar.com** if you have any questions.

- ✓ Business is located in New Jersey
- ✓ The group's Tax ID in their application matches their tax documents
- ✓ WR-30 document is from last or current quarter
- ✓ 75% of the eligible employees must enroll in Oscar. Valid waivers include Spousal or Parental coverage, Medicare, Medicaid, Tricare, NJ FamilyCare, and group coverage from another employer
- ✓ The employer is making at least a 10% contribution to the group's coverage
- ✓ Each enrolling employee must have at least one of the supporting documents:
  - ✓ Name is on the WR-30
  - ✓ Name on most recent payroll documents
  - ✓ 2 weeks payroll is required for new employees who aren't listed on the most recent WR-30
- ✓ For COBRA enrollees, the employer must submit the last WR-30 that the enrollee appeared on
- ✓ Enrolling employees' SSNs match the employee SSNs on the business' tax documents
- ✓ One person groups must submit ownership documentation. As a reminder, businesses must enroll at least one non-owner, common law employee

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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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New Jersey
Application for Small Group Health Benefits Policy

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

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 employee	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.

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New Jersey Small Employer Certification

Section 1: Employer information

Legal name of employer		
Employer street address		
City	State	ZIP
Group policy number or group number (if a current customer)		

Section 2: Employee and small employer definitions

For purposes of certification as a New Jersey Small Employer, an employer is considered to to be a Small Employer if the Employer satisfis the definiton set forth below. The definition of Small Employer counts employees as defined below:

Employee and Small Employer Definitions
Employee means an employee of the Policyholder. An individual and his or her legal spouse when the business is owned by the individual or by the individual and his or her legal spouse, partners in a partnership, sole proprietors, a 2-percent S corporation shareholder and independent contractors are not employees of the Policyholder.

Small Employer means in connection with a Group Health Plan with respect to a Calendar Year and a Plan Year, an employer who employed an average of at least 1 but not more than 50 employees on business days during the preceding Calendar Year and who employs at least 1 employee on the first day of the Plan Year.

All persons treated as a single employer under subsection (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as one employer.

In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether such employer is a small or large employer shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current calendar year.

The following calculation must be used to determine if an employer employs at least 1 but not more than 50 employees. For purposes of this calculation:

a) Employees working 30 or more hours per week are full-time employees and each full-time employee counts as 1;
b) Employees working fewer than 30 hours per week are part-time and counted as the sum of the hours each part-time employee works per week multiplied by 4 and the product divided by 120 and rounded down to the nearest whole number.

Add the number of full-time employees to the number that results from the part-time employee calculation. If the sum is at least 1 but not more than 50 the employer employs at least 1 but not more than 50 employees.

Please note: Small Employer includes an employer that employs more than 50 full-time employees if the employer's workforce exceeds 50 full-time employees for no more than 120 days during the calendar year and the Employees in excess of 50 who were employed during such 120-day or fewer period were seasonal workers.

Full-Time Employee Definition
The definition of Full-time Employee is used to determine eligibility for coverage under a small employer plan. Full-time employees are counted when determining participation for a small employer.

Full-Time Employee means an employee who works a normal work week of 25 or more hours. Work must be at the Policyholder's regular place of business or at another place to which an employee must travel to perform his or her regular duties for his or her full and normal work hours.

Please note that the above definition of Small Employer above considers full-time to be 30 hours per week and that definition of full-time is used solely for determining whether an employer is a Small Employer. For purposes of determining which employees are eligible for insurance under a Small Employer plan and whether the Small Employer meets the participation requirement, full-time is defined as 25 hours per week.

Section 3: Employees by location

Please indicate below the number of employees by work location/State. Refer to the definition of "employee" on page 1. All employees must be included, regardless of whether or not they currently have medical coverage and through whom that coverage is provided.

Work location (list by State)	Number of employees or former employees			
	Full-time	Part-time	COBRA or State Continuees	Other

Section 4: Participation rate

Please indicate below the number of employees by work location/State. Refer to the definition of "employee" on page 1. All employees must be included, regardless of whether or not they currently have medical coverage and through whom that coverage is provided.

Total # full-time employees:	Total # full-time employees applying/enrolling for health benefits coverage:

Total # full-time employees waiving health benefits coverage under the policy with coverage under their spouse's or parent's group coverage, Medicare, Medicaid, or NJ FamilyCare or Tricare or any other group Health Benefits Plan through a different employer:

Total # full-time employees waiving health benefits coverage under the policy with coverage under a Health Benefits Plan issued by another carrier and offered by the small employer:

→ Please separately list the name(s) of the other carrier(s) and the number of employees covered under each:

Total # full-time employees waiving health benefits coverage under the policy without coverage under a spouse's or parent's group coverage; Medicare, Medicaid, or NJ FamilyCare or Tricare or any other Health Benefits Plan:

Total # Employees in an ineligible class or classes:

Section 5: Federal laws and the small employer

The following information will be used to determine how certain federal laws apply to the Small Employer.

Is your firm subject to Working Aged Provisions of federal law (TEFRA/DEFRA)? (You may be subject to the law if you employed 20 or more employees[1] for 20 weeks in the current or prior calendar year): ☐ No ☐ Yes

→ If yes, provide the number of full-time and part-time employees you employed for at least 20 or more weeks in the current or prior calendar year:

Is your firm subject to the requirements of the federal COBRA law? (You may be subject to the law if you employed 20 or more employees[1] during 50% or more of the working days during the previous calendar year): ☐ No ☐ Yes

→ If yes, provide the number of full-time and part-time employees you employed during 50% or more of the working days during the previous calendar year. (Each part-time employee counts as a fraction of an employee, with the fraction equal to the number of hours the part-time employee worked divided by the hours an employee must work to be considered full-time):

What is the average number of employees you employed during the entire previous calendar years, regardless of whether they were eligible or enrolled for group coverage? (When answering this question, please count any employee for whom your company issues a W-2 and include full-time, part-time, and seasoned workers)

[1]For purposes of this question "employee" includes: full-time employees, part-time employees, seasonal employees, temporary employees, employees who are union members, owners, partners, officers and excludes self-employed persons, independent contractors (1099), directors. Each part-time employee counts as a fraction of an employee, with the fraction equal to the number of hours the part-time employee worked divided by the hours an employee must work to be considered full-time.

Section 6: Certification as a Small Employer in the State of New Jersey (for a Group Health Benefits Plan)

Please sign and date appropriate section indicating whether or not you meet the definition of a small employer.

☐ **I certify that I qualify as a Small Employer in the State of New Jersey.**

AND

☐ I certify that the information provided to Oscar Garden State Insurance is true and complete. I understand that if the above information is not complete or is not provided to Oscar Garden State Insurance Company, in a timely manner, then health benefits coverage does not have to be offered or continued. I further understand that incomplete or untrue information may void health benefits coverage.

☐ I certify that I have obtained and maintain a stand-alone pediatric dental plan for all employees and dependents enrolling for health benefits coverage.

Signature of Officer, Partner or Owner — Sign here X	Title
Print Name of Officer, Partner or Proprietor Date	Date
Signature of Witness — Sign here X	Date

☐ **I certify that I am NOT a Small Employer in the State of New Jersey, as defined above.**

Signature of Officer, Partner or Owner — Sign here X	Title
Print Name of Officer, Partner or Proprietor Date	Date
Signature of Witness — Sign here X	Date

Any person who includes any false or misleading information on an application or enrollment form or certification for a health benefits plan is subject to criminal and civil penalties.

Section 7: Census information

Complete this section if you have certified that the Employer is a Small Employer.

Please include the following persons in the following list:

A) Employees, owners, partners, and officers who are actively working for the employer on a regular basis, and are paid by the employer on a regular basis, whether or not they are eligible to be covered under the policy.

A) Employees, owners, partners and officers who are not working, but who are currently covered under the employer's health benefits plan for reasons such as continuation of coverage or total disability.

Please use the following letters to indicate Status:
O: Owner, partner or officer
F: Full-time employee who works 25 or more hours per week
P: Part-time employee who works less than 25 hours per week
S: Seasonal employee (employee works 120 days or fewer per year)
D: Totally Disabled employee
C: Continuee under state or federal law
U: Employee participating in an employee welfare arrangement established pursuant to a collective bargaining agreement.

Name	Job title	Date of employment	Hours worked per week	Status	Work location (State)	Date of Birth

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New Jersey Small Employer Health Benefits Waiver of Coverage

Group policy number	Policyholder name	
Employee last name	First name	Middle name
Date of employment (mm/dd/yyyy)	Date of birth (mm/dd/yyyy)	

Marital status

☐ Single ☐ Married ☐ Widowed ☐ Divorced

I was given the opportunity to enroll in this plan of group health benefits offered by my employer and insured by Oscar Garden State Insurance Corporation. I refuse the following:

☐ Employee, spouse and child(ren) coverage ☐ Spouse coverage ☐ Child(ren) coverage

Reason for refusal (please check all appropriate boxes):

☐ Other fully-insured Group Health Plan sponsored by this employer

☐ Other group coverage sponsored by another organization

☐ Other reasons (please explain):

☐ Other Group Health Plan sponsored by my spouse's employer

☐ Covered under Medicare

Please identify Group Health Plan(s) and provide names(s) of policyholder(s), carrier(s) and policy number(s).

Policyholder last name	First name	Middle name
Carrier	Policy number	
Policyholder last name	First name	Middle name
Carrier	Policy number	
Policyholder last name	First name	Middle name
Carrier	Policy number	

If you are declining enrollment for yourself or your dependents (including your spouse) because of other Group Health Plan coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 90 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents provided that you request enrollment within 30 days after marriage, birth, adoption or placement for adoption. I understand that if I later wish to enroll for any of the coverage(s) refused, I will be required to submit an Enrollment Form.

Signature of employee — Sign here X	Date (mm/dd/yyyy)
Signature of witness — Sign here X	Date (mm/dd/yyyy)

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New Jersey 2018 Employee Enrollment Application / Change Request

Instructions: You, the employee, must complete this application. You are solely responsible for its accuracy and completeness. To avoid the possibility of delay, answer all questions and be sure to sign and date your application. Please complete this form in blue or black ink and submit to your employer when complete.

Section A: Information provided by your employer (to be completed by the employer)

Employer name	Employer group ID (ex: BIZ12345678)	
Employee's work address		
City	State	ZIP code
Employment status (check all options that apply):	☐ Active ☐ Union ☐ Non-union ☐ Hourly ☐ Salary ☐ Other (please explain):	
Employee's class	Date of hire (mm/dd/yyyy)	Hours worked per week

Section B: Application type

Application type	☐ New application	☐ Change benefits plan	☐ Information update (name, address, etc.)
	☐ Add/remove a dependent	☐ Termination	
Application reason	☐ Open enrollment	☐ New hire	☐ Rehire
	☐ **COBRA**	☐ **New Jersey Small Group Continuation (NJSGC)**	☐ **Qualifying Life Event**
	☐ Other (please explain):		

If you selected **COBRA** or **NJSGC** as the application reason above, please select one of the following qualifying life events:

- ☐ Left employment
- ☐ Reduction in hours
- ☐ Death
- ☐ Divorce or legal separation
- ☐ Loss of dependent child status
- ☐ Medicare entitlement

Continuation qualifying event date (mm/dd/yyyy):

If you selected **Qualifying Life Event** as the application reason above, please select one of the following applicable qualifying life events:

- ☐ Loss of coverage*
- ☐ Marriage
- ☐ Birth
- ☐ Adoption*
- ☐ Court-ordered dependent addition*
- ☐ Moved to service area*

Other qualifying event date (mm/dd/yyyy):

* Indicates that appropriate documentation must be submitted along with this form to be eligible for coverage.

Section C: Member information

Instructions: The below information must be completed for the subscriber and any additional family members to be covered. An eligible dependent may be your spouse, domestic partner, your children, your spouse's children or your domestic partner's children, at the option of your employer.

Coverage of a child dependent will continue to the end of the calendar month in which the child turns age 26 unless:

- He or she qualifies as a disabled person (if you have a disabled dependent, please call us at (855) 672-2784 to request a disabled dependent form).
- Your dependent qualifies for and enrolls in the Over-Age Child Dependent Under 31, which extends coverage for young adults through age 31.

	Employee	Spouse	Child	Child 2
Full name				
Social security number	- - ☐ Not available	- - ☐ Not available	- - ☐ Not available	- - ☐ Not available
Check all that apply:		☐ Domestic partner ☐ Employee of this business	☐ Disabled ☐ Dependent under 31 ☐ Employee of this business	☐ Disabled ☐ Dependent under 31 ☐ Employee of this business
Gender	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
Date of birth (mm/dd/yyyy)				
For the section below, if all members share the same details - only fill out the first column. However, if there are differences or if a dependent is enrolling as a Young Adult, please fill out the other respective columns.				
Address line 1				
Address line 2 (optional)				
City				
State				
ZIP code				
County				
Phone (xxx) xxx - xxxx				
Email				
On the day your coverage begins, if you or any of your family members will be eligible or covered by Medicare or other coverage fill out the section below.				
Eligible for Medicare	☐ Yes ☐ No If yes, why? ☐ Age ☐ Disability ☐ ESRD Onset date:	☐ Yes ☐ No If yes, why? ☐ Age ☐ Disability ☐ ESRD Onset date:	☐ Yes ☐ No If yes, why? ☐ Age ☐ Disability ☐ ESRD Onset date:	☐ Yes ☐ No If yes, why? ☐ Age ☐ Disability ☐ ESRD Onset date:

Medicare coverage (check appropriate box and list effective date and Medicare ID number)	☐ Part A: / / ☐ Part B: / / ☐ Part C: / / ☐ Part D: / / ID number:	☐ Part A: / / ☐ Part B: / / ☐ Part C: / / ☐ Part D: / / ID number:	☐ Part A: / / ☐ Part B: / / ☐ Part C: / / ☐ Part D: / / ID number:	☐ Part A: / / ☐ Part B: / / ☐ Part C: / / ☐ Part D: / / ID number:
Other health coverage (check appropriate box and list coverage dates, carrier name and Policy number)	☐ Individual ☐ Group Start date: / / End date: / / Carrier name: Policy number:	☐ Individual ☐ Group Start date: / / End date: / / Carrier name: Policy number:	☐ Individual ☐ Group Start date: / / End date: / / Carrier name: Policy number:	☐ Individual ☐ Group Start date: / / End date: / / Carrier name: Policy number:

Section D: Choose your plan

Not all plans listed may be available - check with your employer for more details. All plans below include pediatric dental coverage.

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

Section E: Terms, conditions, and authorizations

Please read this section carefully before signing the application:

W-9 Certification:
As part of the W-9 Certification required by the Internal Revenue Service (IRS), I certify that the Social Security number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me) and I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the IRS that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding and I am a U.S. citizen or other U.S. person.

In signing this, I represent that:
I am an Eligible Employee (as defined by New Jersey state and federal law), and I am requesting coverage for myself and all Eligible Dependents (as defined by New Jersey state and federal law) listed and authorize my Employer to deduct any required contributions for this insurance from my earnings. I understand all benefits are subject to conditions stated in the Group Contract and coverage documents.

I have read or have had read to me the completed application, and I realize any false statement or misrepresentation in the application may result in loss of coverage.

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.

Applicant signature	Date (mm/dd/yyyy)
Sign here **X**	