Cigna + oscar

Employee Enrollment Application / Change Request Form - California 2022

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.

California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

Section A: Employer information

Employer name	Employer group ID (ex: BIZ12345678 – if unavailable, leave blank)
Employee's status (check all options that apply)	☐ Hourly ☐ Salary
Average number of hours worked by employee per week	Date of hire (mm/dd/yyyy)

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 ☐ Cal-COBRA ☐ Qualifying Life Event
☐ Other (please explain):

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

☐ Left employment
☐ Reduction in hours
☐ Death
☐ Divorce or legal separation
☐ Loss of dependent status**
☐ Medicare entitlement
☐ Exhausted COBRA (Cal-COBRA applicants only)

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 and its date*:

☐ Loss of minimum essential coverage
☐ Loss of qualifying health coverage
☐ Marriage
☐ Birth
☐ Adoption
☐ Court-ordered dependent addition
☐ Change in legal guardianship
☐ Change in primary place of living
☐ Released from incarceration Return
☐ from active duty
☐ Other (please specify):

☐ Became a dependent**

☐ Previous health coverage issuer substantially violated a material provision of the health coverage contract

☐ Gaining access to new health benefit plans as a result of a permanent move.

Qualifying event date (mm/dd/yyyy):

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

* A permanent employee who is actively engaged on a full-time basis in the conduct of the business of the small employer with a normal workweek of at least 30 hours, at the small employer's regular places of business, who has met any statutorily authorized applicable waiting period requirements.

**An eligible dependent may be your spouse, domestic partner, your children, your spouse's children or your domestic partner's children, or children for whom the employee has assumed a parent-child relationship.

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, a child for whom you have an assumed parent-child relationship, your spouse's children or your domestic partner's children, or children for whom the employee has assumed a parent-child relationship.

Coverage of a child dependent will continue to the end of the 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 after the initial enrollment to request a disabled dependent form to be mailed to the employee, or visit hioscar.com/forms). The disabled dependent form may be mailed to you and must be returned within 60 days of receipt for coverage to continue. The form must be completed and returned within 60 days of receipt in order for coverage to continue.

	Employee	Spouse	Child	Child 2
First name				
Middle initial				
Last name				
Social Security Number or TIN	– – ☐ No SSN	– – ☐ No SSN	– – ☐ No SSN	– – ☐ No SSN
Sex	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
Date of birth (mm/dd/yyyy)				
Preferred language (optional)				
Check all that apply		☐ Domestic partner ☐ Employee of this business	☐ Disabled ☐ Employee of this business	☐ Disabled ☐ Employee of this business
For the section below, if all members share the same details - only fill out the first colum However, if there are differences, fill out the other respective columns. Please note: PO Boxes do not count as a valid address.				
Residential address, line 1				
Residential address, line 2				
City and state				
ZIP code				
County				
Email				
Phone (xxx) xxx - xxxx				

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?	☐ No ☐ Yes If yes, why? ☐ Age ☐ Disability ☐ ESRD Onset date: / /	☐ No ☐ Yes If yes, why? ☐ Age ☐ Disability ☐ ESRD Onset date: / /	☐ No ☐ Yes If yes, why? ☐ Age ☐ Disability ☐ ESRD Onset date: / /	☐ No ☐ Yes If yes, why? ☐ Age ☐ Disability ☐ ESRD Onset date: / /
Medicare coverage Check appropriate box and list effective date (mm/dd/yyy) 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 (mm/dd/yyyy), 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.

☐ Cigna+Oscar LocalPlus Bronze $1000
☐ Cigna+Oscar LocalPlus Bronze $5750 HSA
☐ Cigna+Oscar LocalPlus Bronze $6000
☐ Cigna+Oscar LocalPlus Bronze $6300
☐ Cigna+Oscar LocalPlus Silver $0
☐ Cigna+Oscar LocalPlus Silver $1950
☐ Cigna+Oscar LocalPlus Silver $2250
☐ Cigna+Oscar LocalPlus Silver $2500 HSA
☐ Cigna+Oscar LocalPlus Silver $2600
☐ Cigna+Oscar LocalPlus Gold $0
☐ Cigna+Oscar LocalPlus Gold $250
☐ Cigna+Oscar LocalPlus Gold $500
☐ Cigna+Oscar LocalPlus Gold $750
☐ Cigna+Oscar LocalPlus Gold $1350
☐ Cigna+Oscar LocalPlus Platinum $0/$20
☐ Cigna+Oscar LocalPlus Platinum $0/$10
☐ Cigna+Oscar LocalPlus Platinum $250
☐ Cigna+Oscar LocalPlus Platinum $500

☐ Cigna+Oscar Open Access Plus Bronze $1000
☐ Cigna+Oscar Open Access Plus Bronze $5750 HSA
☐ Cigna+Oscar Open Access Plus Bronze $6000
☐ Cigna+Oscar Open Access Plus Bronze $6300
☐ Cigna+Oscar Open Access Plus Silver $0
☐ Cigna+Oscar Open Access Plus Silver $1950
☐ Cigna+Oscar Open Access Plus Silver $2250
☐ Cigna+Oscar Open Access Plus Silver $2500 HSA
☐ Cigna+Oscar Open Access Plus Silver $2600
☐ Cigna+Oscar Open Access Plus Gold $0
☐ Cigna+Oscar Open Access Plus Gold $250
☐ Cigna+Oscar Open Access Plus Gold $500
☐ Cigna+Oscar Open Access Plus Gold $750
☐ Cigna+Oscar Open Access Plus Gold $1350
☐ Cigna+Oscar Open Access Plus Platinum $0/$20
☐ Cigna+Oscar Open Access Plus Platinum $0/$10
☐ Cigna+Oscar Open Access Plus Platinum $250
☐ Cigna+Oscar Open Access Plus Platinum $500

Section E: Terms, conditions, and authorizations

Please read this section carefully before signing the application. Submitting this enrollment form electronically is voluntary. Upon receipt of this form by the Carrier, you will receive an email confirmation. You may opt out of completing this form electronically or receiving confirmation electronically at any time. To opt out, discontinue filling out this form and inform your representative that you wish to submit a paper version of the form, which can be found here. If you need to change your email address, please contact your broker or benefit administrator. Your broker or benefit administrator will need to change your email address of record via business.hioscar.com and re-send you the invitation to complete your application. At that time, you will be able to sign up with your new email address.

Eligible Employee means:
An active employee of the Employer who works the number of hours per week to be eligible for benefits as defined by the Employer, who meets the definition of "Eligible Employee" under California. Employment must be verifiable from state or federal wage tax reports;

- An Eligible Employee, as defined above, who enters into employment after the coverage effective date and who completes the group imposed waiting period for eligibility (if any) and applies for coverage within 30 days of becoming eligible to enroll in coverage;
- Any other class of persons identified by the Employer, provided that written approval of their eligibility is obtained from the Company(ies); or
- An Eligible Employee, who is eligible for continued coverage under California State or Federal laws

<u>Eligible Dependent means:</u>

- Your spouse, domestic partner, or child age 26 or younger, including a newborn, natural child, a child for whom you have assumed a parent-child relationship, or a child placed with you for adoption, a stepchild or any other child for whom you have legal guardianship or court ordered custody. Coverage for children will end on the last day of the month in which the children reach age 26 unless he or she qualifies as a disabled person.
- A child (at any age during initial or continued enrollment), who is incapable of self-sustaining employment by reason of physically or mentally disabling injury, illness, or condition; and is chiefly dependent upon the Subscriber for support and maintenance.
- Dependents eligible for continued coverage under California State or Federal laws.

In signing this, I represent that:

- I am requesting coverage for myself and all Dependents as listed above 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 Policy.
- I have read or have had read to me the completed application, and I realize fraud or intentional misrepresentation of material fact in the application may result in loss of coverage.

Binding Arbitration
All disputes including but not limited to disputes relating to the delivery of services under the agreement or any other issues related to the agreement and claims of medical malpractice must be resolved by binding arbitration (with the sole exception of Adverse Benefit Determinations, as defined in Section 147.136 of Title 45 of the Code of Federal Regulation), if the amount in dispute exceeds the jurisdictional limit of small claims court and the dispute can be submitted to binding arbitration under applicable federal and state law, including but not limited to, the patient protection and affordable care act. It is understood that any dispute including disputes relating to the delivery of services under the agreement or any other issues related to the agreement, including 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 permitted and provided by federal and 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.
You and Cigna agree to be bound by this arbitration provision and acknowledge that the right to a jury trial or to participate in a class action is waived for both disputes relating to the delivery of service under the agreement or any other issues related to the agreement and medical malpractice claims.
The Federal Arbitration Act shall govern the interpretation and enforcement of all proceedings under this BINDING ARBITRATION section. To the extent that the Federal Arbitration Act is inapplicable, or is held not to require arbitration of a particular claim, State law governing agreements to arbitrate shall apply. The arbitration findings will be final and binding except to the extent that State or federal law provides for the judicial review of arbitration proceedings.
The arbitration is initiated by the Member making a written demand on Us. The arbitration will be conducted by a single neutral arbitrator from Judicial Arbitration and Mediation Services ("JAMS"), according to JAMS' applicable Rules and Procedures. If for any reason JAMS is unavailable to conduct the arbitration, the arbitration will be conducted by a single neutral arbitrator from another neutral arbitration entity, by agreement of the Member and Oscar, or by order of the court, if the Member and Cigna cannot agree. If the parties cannot agree on the individual neutral arbitrator, the arbitrator will be selected in accordance with JAMS Rule 15 (or any successor rule).
However, in the case of a medical malpractice dispute in which the total amount of damages claimed is fifty thousand dollars ($50,000) or less, the parties may select a single neutral arbitrator who shall have no jurisdiction to award more than fifty thousand dollars ($50,000). If the parties are unable to agree on the selection of a neutral arbitrator, the method provided in Section 1281.6 of the CA Code of Civil Procedure should be utilized.

Applicant signature	Printed name	Date (mm/dd/yyyy)
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