GROUP ENROLLMENT/CHANGE REQUEST

oscar	Group Information – to be completed by Employer:		
Oscar Garden State Insurance Corporation	Group Name:	Group ID:	Class:

A. Type of Activity – to be completed by Employer. *Refer to instructions on page 5 before completing this form. Print clearly.*

	Activity – Check all that apply	Effective Date/ Date of Event	Date of Hire/Reason for Change
1. ADD	☐ Enrollment of a new member ☐ Add Spouse ☐ Add Civil Union Partner ☐ Add Domestic Partner ☐ Add Dependent Child ☐ Add Over-Age Child as a Dependent Under 31 *(and complete section A 4)*	_____/_____/_____ _____/_____/_____ _____/_____/_____ _____/_____/_____ _____/_____/_____ _____/_____/_____	Date of Hire: _____/_____/_____ _____ _____ _____ _____ _____
2. REMOVE	☐ Employee Withdrawal/Termination ☐ Remove Spouse ☐ Civil Union Partner ☐ Remove Domestic Partner ☐ Remove Dependent Child ☐ Remove Over-Age Child as a Dependent Under 31	_____/_____/_____ _____/_____/_____ _____/_____/_____ _____/_____/_____ _____/_____/_____ _____/_____/_____	_____ _____ _____ _____ _____ _____
3. OTHER CHANGE	☐ Name Change ☐ Change Plan ☐ Other	_____/_____/_____ _____/_____/_____ _____/_____/_____ _____/_____/_____	_____ _____ _____ _____

4. COVERAGE CONTINUATION

☐ For Employee
- ☐ Total Disability*
- ☐ COBRA/NJSGC
  - Length of Continuation (in months):
  - ☐ 18 ☐ 29
  - Date of Loss of Coverage: ___/___/___
  - Qualifying Event #:_____**
  - Date of Qualifying Event: ___/___/___

**Attach proof of disability*

☐ For Spouse/Civil Union Partner*
- Length of Continuation (in months):
- ☐ 18 ☐ 36
- Date of Loss of Coverage: ___/___/___
- Qualifying Event #:_____**
- Date of Qualifying Event: ___/___/___

**Civil union partners are eligible to make an election pursuant to NJSGC, if applicable.*

☐ For Dependent or Over-age Child
- ☐ COBRA/NJSGC
  - Length of Continuation (in months):
  - ☐ 18 ☐ 36
  - Loss of Coverage: ___/___/___
  - Qualifying Event #:_____**
  - Date: ___/___/___
- ☐ Dependent Under 31
  - Qualifying Event #:_____**

***Qualifying event #s: see list in Instructions.*

B. Employee Information – to be completed by the Employee	Name (Last, First, MI):	SSN:

Home

Street/Apt:_____
Street/Apt:_____
City:_____ State:_____ Zip Code: _____

Birthdate (mm/dd/yyyy):

☐ Male ☐ Female

Phone: (_____)_____
Email: _____

Work

Employer Name:_____
Address:_____
City:_____ State:_____ Zip Code: _____

Phone: (_____)_____
Email:
_____
Employment Date: _____/_____/_____
Hours worked per week:_____

☐ Add ☐ Remove ☐ Continuation ☐ Other Change *If a name change, indicate prior name:*

Other Health Coverage? ☐Yes ☐No *If yes:*
Payer Name: _____
Policy #: _____
Medicare ID#, if any:

C. Plan Option – to be completed by the Employee *Check one plan name. Please note: all plans include pediatric dental.*

☐ Oscar Classic Bronze $3,000 EPO
☐ Oscar Classic Silver $1,500 EPO
☐ Oscar Classic Silver $2,000 EPO
☐ Oscar Saver Silver $2,500 PPO
☐ Oscar Classic Gold $2,400 EPO

D. Other Individuals Covered – to be completed by the Employee *Identify individuals other than yourself for whom you are adding/changing/removing/continuing coverage. Attach additional pages if necessary, with your signature and dated. Attach proof of disability.*

1. Spouse; Domestic or Civil Union Partner	**2.Child**	**3. Child**	**4. Child**
☐Add ☐ Remove ☐Other ☐Continue Spouse ☐Continue CU Partner (NJSGC) Continue CU Partner (COBRA/NJSGC) Name (last, first, MI) L:_____ F:_____ MI: Birthdate (mm/dd/yyyy):	☐ Add ☐ Remove ☐ Other ☐ Continue Name (last, first, MI) L:_____ F:_____ MI: Birthdate (mm/dd/yyyy):	☐ Add ☐ Remove ☐Other ☐ Continue Name (last, first, MI) L:_____ F:_____ MI: Birthdate (mm/dd/yyyy):	☐ Add ☐ Remove ☐Other ☐ Continue Name (last, first, MI) L:_____ F:_____ MI: Birthdate (mm/dd/yyyy):
☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
Social Security Number: Other Health Coverage ☐ Yes ☐ No *If yes:* Payer Name: _____ Policy #: _____ Medicare ID #:	Social Security Number: Other Health Coverage ☐ Yes ☐ No *If yes:* Payer Name: _____ Policy #: _____ Medicare ID #:	Social Security Number: Other Health Coverage ☐ Yes ☐ No *If yes:* Payer Name: _____ Policy #: _____ Medicare ID #:	Social Security Number: Other Health Coverage ☐ Yes ☐ No *If yes:* Payer Name: _____ Policy #: _____ Medicare ID #:
Employed? Yes No *If yes, complete Section E1*	If last name is different from employee's, please explain:	If last name is different from employee's, please explain:	If last name is different from employee's, please explain:
Home or billing address same as Employee? Yes *If* No *NO, complete Section E2*	Living with Employee ☐ Yes ☐ No *If NO, complete Section F*	Living with Employee ☐ Yes ☐ No *If NO, complete Section F*	Living with Employee ☐ Yes ☐ No *If NO, complete Section F*

E. Additional Spouse/Civil Union Partner/Domestic Partner Information – to be completed by Employee. If *not applicable, please mark as "NA."*	1. Employer Name:_____ Employer Address:_____ City, State, Zip Code:_____ Employer Phone: ( )
2a. Street/Apt:_____ Street/Apt:_____ City, State, Zip Code:_____	2b. Please explain why the address is different: _____ _____

F. Additional Child Information – to be completed by Employee. *Provide information below about children listed in Section D,* **if** *they have a different address from the employee. If multiple children are at an address, you may list them together. Attach additional pages as necessary, signed and dated.*

Name(s):_____	Name(s):_____
Street/Apt:_____	Street/Apt:_____
Street/Apt:_____	Street/Apt:_____
City, State, Zip Code: _____	City, State, Zip Code:_____
Reason:_____	Reason:_____

G. Race/Ethnicity – to be completed by the Employee, at his/her option. *NOTE: your response is appreciated but NOT required!*	*Choose a category that most closely describes you:* ☐ American Indian or Alaskan Native ☐ Black, not of Hispanic origin ☐ Hispanic ☐ Asian or Pacific Islander ☐ White, not of Hispanic origin
H. Employee Signature	I represent that all the information supplied in this application is true and complete. I hereby agree to the Conditions of Enrollment set forth in this Enrollment/Change Request form. I authorize deductions from my earnings for any contributions required from me. Signature: _____ Date: _____

I. Over-Age Child's Signature	I represent that all the information supplied in this application regarding the Dependent Under 31 Continuation Election is true and complete. I hereby agree to the Conditions of Enrollment set forth in this Enrollment/Change Request form. I hereby agree to make contributions required from me for the Dependent Under 31 Continuation Election. Signature: _____ Date: _____
J. Employer Verification	The requested activity is believed eligible and is approved by the Employer. ☐ ☐ Employer Representative: _____ Date: _____ Representative's Title: _____

CONDITIONS OF ENROLLMENT -- APPLICANT ACKNOWLEDGEMENTS AND AGREEMENTS

On behalf of myself and the dependents listed in this Enrollment/Change Request form, I acknowledge that:

1. I authorize any physician or medical professional, hospital, clinic or other medical care institution, carrier, consumer reporting agency, and any employer to give Oscar Garden State Insurance Corporation, or any consumer reporting agency acting on behalf of Oscar Garden State Insurance Corporation, information pertaining to employment, other health coverage, and medical advice, treatment or supplies for any physical or mental condition relevant to me or a minor dependent applying for coverage. I agree that this authorization shall be valid for 30 months from the date I sign this Enrollment/Change Request form, unless revoked at an earlier date.
2. I agree that, if I revoke this authorization before it expires, such revocation shall not affect any action that Oscar Garden State Insurance Corporation has taken in reliance on the authorization.
3. I understand I may receive a copy of this authorization if I request one.
4. I agree Oscar Garden State Insurance Corporation will provide coverage in accordance with the terms of the contract for the group policy.
5. I agree that the provision of coverage and benefits is contingent upon payment of premiums and may be terminated in accordance with the terms of the group policy if premiums are not paid timely. I authorize my Employer to withhold payments from my wages as contribution to the premium, as appropriate.

INSTRUCTIONS

Employers – You must complete the Employer Group Information and sections A and J in order for this application to be processed.

Employees – You must complete sections B through H and submit the signature of each Over-Age Child for which a Dependent Under 31 Continuation Election is made in accordance with Section I in order for this application to be processed.

- Please PRINT except when a signature is requested.
- If a dependent is disabled and you want to continue his or her coverage beyond age 26, you do not have to make a COBRA/NJSGC or Dependent Under 31 election. Instead, select "Other" in Section A3, and attach proof of disability.

Qualifying Events

COBRA and NJSGC
C1. Termination of job or reduction in hours
C2. Employee enrollment in Medicare (COBRA only)
C3. Divorce (COBRA/NJSGC); civil union dissolution (NJSGC)
C4. Death of employee
C5. Loss of dependent child status under the plan
C6. Disability (occurring subsequent to another qualifying event)
Dependent Under 31
D1. Loss of dependent status and otherwise eligible
D2. Reestablish eligibility: residency
D3. Reestablish eligibility: nonresident full-time student
D4. Reestablish eligibility: change in marital status
D5. Reestablish eligibility: change in parental status
D6. Reestablish eligibility: termination of other coverage