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Solicitud de inscripción de empleados / Formulario de solicitud de cambio - California 2020

Instrucciones: Usted (el empleado) debe completar esta solicitud. Usted es el único responsable de que el formulario se complete de forma precisa y completa. Para evitar demoras, responda todas las preguntas y asegúrese de firmar y fechar la solicitud. Complete el formulario con tinta azul o negra y envíeselo a su empleador cuando lo haya finalizado.

Sección A: Información del empleador

Nombre del empleador	ID de grupo de empleador (por ej.: BIZ12345678 - si no está disponible, dejar en blanco)

Estado del empleado (marcar todas las opciones que correspondan):

☐ Activo ☐ Afiliado a sindicato ☐ No afiliado a sindicato
☐ Por hora ☐ Asalariado ☐ Otro (explicar):

Horas trabajadas por empleado por semana	Fecha de contratación (mm/dd/aaaa)

Sección B: Tipo de solicitud

Tipo de solicitud

☐ Nueva solicitud ☐ Cambiar plan de beneficios ☐ Actualización de información (nombre, dirección, etc.)
☐ Agregar/eliminar un dependiente ☐ Finalización

Motivo de la solicitud

☐ Inscripción abierta ☐ Nueva contratación ☐ Recontratación
☐ COBRA ☐ Cal-COBRA ☐ Evento de vida que califique
☐ Otro (explicar):

Si seleccionó **COBRA** o **Cal-COBRA** como el motivo de solicitud anterior, seleccione uno de los siguientes eventos que califican:

☐ Abandono del empleo
☐ Reducción de horas
☐ Fallecimiento
☐ Divorcio o separación legal
☐ Pérdida de la condición de hijo dependiente
☐ Derecho a Medicare
☐ COBRA terminado (solo solicitantes de Cal-COBRA)

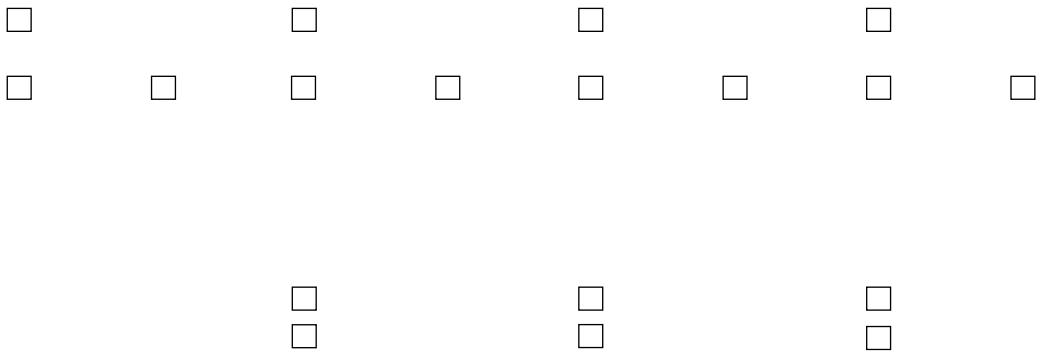
Fecha de continuación del evento que califica (mm/dd/aaaa):

Si seleccionó **Evento de vida que califica** como el motivo de solicitud anterior, seleccione uno de los siguientes eventos de vida que califican aplicables y la fecha*:

☐ Pérdida de cobertura
☐ Matrimonio
☐ Nacimiento
☐ Adopción
☐ Adición de dependiente ordenada por el tribunal
☐ Mudanza al área de servicio
☐ Otro (especificar):

Fecha del evento que califica (mm/dd/aaaa):

*Tenga en cuenta que se debe presentar la documentación adecuada junto con este formulario para ser elegible para la cobertura.



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.

- ☐ Oscar Bronze $8,150 EPO Option 1
- ☐ Oscar Bronze $8,150 EPO Option 2
- ☐ Oscar Bronze 60 HDHP EPO $6,900/0% + Child Dental
- ☐ Oscar Bronze 60 EPO $6,300/$65 + Child Dental

- ☐ Oscar Silver $0 EPO
- ☐ Oscar Silver $1,500 EPO
- ☐ Oscar Silver $2,000 EPO
- ☐ Oscar Silver 70 EPO $2,250/$50+ Child Dental
- ☐ Oscar Silver 70 HDHP EPO $2,500/20% + Child Dental

- ☐ Oscar Gold $0 EPO
- ☐ Oscar Gold $500 EPO
- ☐ Oscar Gold $1,000 EPO
- ☐ Oscar Gold $2,000 EPO
- ☐ Oscar Gold 80 EPO $250/$25 + Child Dental

- ☐ Oscar Platinum $0 EPO Option 1
- ☐ Oscar Platinum $0 EPO Option 2
- ☐ Oscar Platinum 90 EPO $0/$15 + Child Dental

Section E: Terms, conditions, and authorizations

Please read this section carefully before signing the application:

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 "employee" under California State and Federal laws, and approved by Oscar Health Plan of California ("Oscar") as of the effective date. Employment must be verifiable from state or federal wage tax reports;
• An 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;
• Any other class of persons identified by the Employer, provided that written approval of their eligibility is obtained from the Company(ies); or
• An employee, who is eligible for continued coverage under California State or Federal laws.

Eligible Dependent means:
• Your spouse, domestic partner, or child age 26 or younger, including a newborn, natural child, 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.
• An unmarried 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 an Eligible Employee (as defined above), and I am requesting coverage for myself and all Eligible Dependents (as defined above) 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 Policy.
• 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.

Applicant signature	Printed name	Date (mm/dd/yyyy)
Sign here ×		

Note: Oscar reserves the right to collect and review supporting documentation.