Alabama Off-Exchange

Nongroup Enrollment/Change Request

oscar

Choose your plan

[ ] Bronze Classic Standard

[ ] Bronze Classic 4700

[ ] Bronze Elite + PCP Saver Plus

[ ] Bronze Simple Chronic Care CKM

[ ] Silver Classic Standard

[ ] Silver Simple

[ ] Silver Simple Chronic Care CKM

[ ] Gold Classic Standard

[ ] Gold Simple

Oscar ID (if changing an existing plan)

Who are you buying insurance for?

- ○ Individual
- ○ Parent & Child(ren)
- ○ Child only
- ○ Individual & Spouse
- ○ Family

Type of activity

- ○ Add dependent
- ○ Change benefit plan
- ○ Update name and/or address
- ○ Remove dependent
- ○ Special enrollment period following a triggering event, see list in instructions)
- ○ New enrollment
- ○ Marital status change

Requested Start Date ___/___/_____ **Date of QLE** ___/___/_____

Qualifying life event (if applicable)

Who's Covered

	Name (First. Middle initial, Last)	Is dependent disabled?*	Sex (M/F)	Social Security No.	Date of Birth MM/DD/YYYY	Phone number	Email	Eligible for Medicare	Smoker?**
Applicant		○						○	○
Spouse		○						○	○
Child dependent(s)		○						○	○
		○						○	○
		○						○	○
		○						○	○
		○						○	○
		○						○	○

*If you have a disabled dependent over age 26, please contact us at brokers@hioscar.com to request a disabled dependent form

**Within the past 6 months have you used any tobacco products 4 or more times per week, on average, excluding religious or ceremonial use? Tobacco products Include products such as cigarettes. e-cigarettes. cigars, chewing tobacco, snuff, pipe tobacco, and others. Note that when determining your premium. Oscar may consider whether you smoke or use tobacco.

Just a few more questions

Home address (P.O box does not qualify)	Apt #	City	County	State	Zip code

Home phone	Cell phone	Email address

Primary language (if other than English)

Marital Status ○ Single ○ Married ○ Domestic partner

If your mailing address is different than your home address, please enter it below

Home address (P.O box does not qualify)	Apt #	City	County	State	Zip code

Do you maintain a home in another state or country? ○ Yes ○ No

Are you an Arizona resident? ○ Yes ○ No

GA/Broker info (if applicable)

	Name	Writing number or National Producer Number (NPN)	Agency name	Phone	Email
GA					
Broker					
Co-broker					

Please Read the Following Terms & Conditions Carefully

I understand that I have the right to review and cancel the Policy within 10 days of delivery, for a full refund of any premium paid. Any request to cancel must be made in writing within 10 days from the date the Policy is delivered. I understand that Oscar may rescind this Policy for any fraudulent or intentional omission or intentional misrepresentation of material facts in the written information I submitted with this enrollment application. A material fact is information which, if known to Oscar, would have caused Oscar to decline to issue coverage. If this Policy is rescinded, Oscar shall have no liability for the provision of coverage under this Policy. By signing the enrollment application I represent that all responses were true, complete and accurate, to the best of my knowledge, and that should Oscar accept my enrollment application, the enrollment application would become part of the Policy between Oscar and me. By signing the enrollment application, I further agreed to comply with the terms of this Policy.

Signature **Date**

By clicking on "{enrollment button text}," you are signing this enrollment application electronically and consenting to its terms & conditions. You agree your electronic signature is the legal equivalent of your manual signature. Note that Oscar will use either your qualifying event date or date the application was submitted to Oscar to determine your effective date of coverage. We will not use the signature date on this application.

Instructions

- With the exception of the last question, you must complete all sections, and sign and date this form.
- Please print except when a signature is requested.
- If a dependent child is disabled and you want to continue his or her coverage beyond age 26, attach proof of disability and contact Oscar for a Disabled Dependent form.
- If you are applying to add a spouse, civil union partner, domestic partner, or child outside of Open Enrollment please check "Add dependent in the "Type of Activity" section and identify the applicable Qualifying Life Event.
- Eligible for Medicare means the person satisfies the requirements for Medicare but has not yet enrolled in Medicare. Entitled or Enrolled under Medicare parts A or B means you have Medicare and CANNOT enroll in an individual plan
- If you have any questions concerning the benefits or services provided by or excluded under this policy, contact a customer service representative by navigating to "Get help" on hioscar.com or emailing help@hioscar.com before signing this form.
- Keep a copy of this completed application!
- You can print out a temporary ID card on hioscar.com if needed. Coverage must be verified with Oscar prior to visiting with a specialist or admission to a hospital.

Qualifying Life Events include, but are not limited to:

1. Involuntary loss of minimum essential coverage
2. Dependent attained age 26 and lost coverage
3. Marketplace changed your subsidy determination
4. Change in household due to marriage, domestic partnership, birth, adoption or placement for adoption, placement in foster care or a child support order or other court order
5. Gained access to plans as a result of permanent move to a new state
6. No longer incarcerated
7. Became lawfully present
8. Holds or gained status as an Native American or Alaska Native

For a list of Qualifying Life Event documentation, please see hioscar.com/brokers

Eligibility

- You must not be enrolled in or entitled to Medicare Parts A or B.
- If application is made for the Secure Plan the following additional requirements apply:
  - You must be under 30 years old at the beginning of the plan year; OR
  - You must have a Certificate of Hardship Exemption from the Marketplace. Attach a copy to your application.
- The Annual Open Enrollment Period is the designated period of time each year during which you may apply for, or change coverage for, yourself and your dependents. Your application must be received during the designated Annual Open Enrollment Period, unless you've experienced a Qualifying Life Event. For 2026 coverage, the Annual Open Enrollment Period runs from November 1, 2025 through January 15, 2026.
- A Special Enrollment Period lasts for 60 days following a Qualifying Life Event. In certain cases, the applicant may also apply during the 60 days leading up to the Qualifying Life Event.
- Note: If you currently have coverage, and the plan for which you are applying will replace the current coverage, you should not terminate your current policy until the new coverage is active.