Quartz

MINNESOTA NEW GROUP CHECKLIST SMALL GROUPS (1-50)

Name of Group: _____

Requested effective date: _____

THE FOLLOWING DOCUMENTS ARE REQUIRED TO ENSURE YOUR GROUP IS PROCESSED APPROPRIATELY.

Note: Required documents need to be submitted by the **10th of the month prior to the effective date** in order to receive ID cards in a timely manner.

☐ **Employer Group Application –** Please complete all sections for processing.

☐ **Applications & Waivers –** Must be completed by every eligible full-time employee listed on the Quarterly Wage and Tax Form (UC-101). If an employee is married and only taking coverage for themselves, they must complete a waiver for their spouse. Please verify we have all sections completed including signatures to ensure underwriting can process.

☐ **Wage and Tax Form (UC-101) –** Include a copy of the group's most recent report, itemizing all employees (fulltime, part-time, seasonal, termed, etc). **For terminated employees, please provide term date and COBRA election.** Add new employees and indicate date of hire. For any other employees (i.e. owners), explain why they are not on the report. Cover page is also needed.

NOTES:

_____

_____

_____

_____

_____

_____

UH01106GMN (0719)
Offered by Quartz Health Plan MN Corporation.

Minnesota Employer Group Application

☐ New Group

☐ Renewing Group / Change*

Offered by Quartz Health Plan MN Corporation.
840 Carolina Street • Sauk City, WI 53583-1374
(800) 362-3310 • Fax (608) 643-2564
QuartzBenefits.com

You, the Employer and Policyholder, wish to establish and sponsor an Employee Benefit Plan, the terms of which are set forth in the applicable Quartz policy. You understand and agree that the Policyholder is not an insurer with respect to paying claims for benefits under the policy. Quartz has the discretion to interpret policy terms, make decisions regarding eligibility and resolve factual questions. For you to remain eligible under the policy, the following participation requirements must be maintained. **If you fail to meet participation requirements, Quartz will terminate your coverage under the policy. Other termination provisions are stated in the policy.**

INSURANCE COVERAGE WILL NOT BE EFFECTIVE UNTIL WE APPROVE THE GROUP APPLICATION IN WRITING. We have the right to decline coverage only if the Group does not meet participation or contribution requirements listed below. These requirements are not applicable for small employer group applications received between November 15 – December 15. These requirements are not applicable for large employer groups making an initial application for coverage.

When considering participation levels, we do not count as "eligible employees" those employees who have other coverage that is qualifying coverage. Qualifying coverage includes Medicare, Medicaid or other group coverage with benefits similar to those being applied for. An individual plan *may* be qualifying coverage if it has been in force for at least one (1) year. **Note: The following limits will be strictly enforced.**

Eligible Employees	Participating Employees
2 – 4	1
5 – 6	3
7	4
8 – 9	5
10	6
11+	70%

Quartz may terminate coverage if participation falls below the minimum requirements. **UNDER NO CIRCUMSTANCES SHOULD YOU CANCEL YOUR PRESENT GROUP INSURANCE COVERAGE WITHOUT PRIOR WRITTEN NOTICE OF APPROVAL BY QUARTZ.**

*** If an existing Group changes any information contained within this document, for example: legal name, probationary period, benefits, contribution amount, etc., the Group must complete Sections A, B, C, D, E and F of a new Employer Group Application and send it to Quartz. Benefit changes must be submitted to Quartz at least 30 days prior to an existing Group's anniversary date in order for the changes to be effective on the anniversary date.**

Section A – General Employer Information

1.	Exact Legal Name of Employer Group (Policyholder):
	Federal Tax ID: Name of d / b / a (doing business as):
2.	Mailing Address: City: State: Zip Code:
3.	County of primary location within the Quartz service area: Phone Number: ( )
4.	Control Group, if any:
	Control Group Federal Tax ID: Number of employees at Control Group including all subsidiaries:
5.	Is this group affiliated with any other group? ☐ Yes ☐ No If so, is the other group insured by Quartz? ■ Yes ■ No
	If Yes, Name of Group(s):
	Do you want coverage for any subsidiaries? ■ Yes ■ No
	a. If Yes, give legal name, Tax ID, and address of each:
	b. If No, give legal name, Tax ID, and address of each affiliate not included and identify number of employees and insurance carrier for each:
6.	Is your company a municipality? ■ Yes ■ No
7.	Employer Group Contact Name:
	Phone: ( ) Email*:
	**Please note that there is a billing charge if you do not provide an email address for electronic billing.*

ONLY FOR GROUPS WITH MORE THAN 50 TOTAL EMPLOYEES

8.	Is this coverage part of a union negotiated agreement? ☐ Yes ☐ No If Yes, Next Union Contract Review Date: _____ *(Month / Day / Year)*
9.	Nature of Business:
10.	How long has your company been in business?

Section B – Plan Selection

1.	For Groups with 50 or fewer employees: Quartz Benefit Plan Name(s): _____ Please write in the plan name exactly how it appears on the rate sheet.

Section C – Plan Information

1.	Requested effective date: (COVERAGE IS NOT EFFECTIVE UNTIL WE NOTIFY YOU IN WRITING)
2.	Hourly Requirement: ☐ 30 hours (Default) ☐ 20 hours
3.	Do you currently have any former employees who have elected coverage and are covered under COBRA or state continuation? ☐ Yes ☐ No If Yes, indicate names of individuals and their expiration dates:
4.	If your company is exempt from state workers' compensation requirements, check here: ☐
5.	Percent of medical insurance premium paid by Employer: Single: _____% (Minimum Requirement for Small Groups is 50%) Family: _____%
6.	Are you requesting a Health Reimbursement Account? ☐ Yes ☐ No If yes, name of vendor:
7.	Probationary Period for new employees (May not exceed 90 calendar days) First of the month following: ☐ 0 days ☐ 30 days ☐ 60 days **OR** Immediately following: ☐ 0 days ☐ 30 days ☐ 60 days ☐ 90 days
8.	Is the probationary period the same as listed in question 7 for employees in the following situations: (applicant must meet group's probationary period first before these provisions apply) Changing from Part-time to Full-time: ☐ Yes ☐ No **If no, please explain eligibility guidelines:**
	Return from leave of absence within 12 months: ☐ Yes ☐ No **If no, please explain eligibility guidelines:**
	Return from layoff within 12 months:: ☐ Yes ☐ No **If no, please explain eligibility guidelines:**
	Rehire within 6 months: ☐ Yes ☐ No **If no, please explain eligibility guidelines:**
	Would you like the probationary period waived for initial enrollment? ☐ Yes ☐ No

ONLY FOR GROUPS WITH MORE THAN 50 TOTAL EMPLOYEES

9.	Are you applying for replacement of your current group medical coverage? ☐ Yes ☐ No If Yes, you must furnish the following information:
	Name of current group carrier: Original effective date: **Attach your most recent billing statement.**
10.	Probationary Period for rehires within 13 weeks (this Affordable Care Act 'pay or play' provision only applies to groups with more than 50 total employees): ☐ Effective date of rehire ☐ Effective first of the month following rehire *** The employee termination date will be the first of the month following the date of termination.**
11.	Do you have variable hour employees? ☐ Yes ☐ No If yes, please explain eligibility guidelines:
12.	Are you requesting domestic partner coverage? ☐ Yes ☐ No

Section D – Retired Employees

If you want to provide medical benefits to retired employees, please give attained age and years of service for retiree class eligibility. A retiree class will be considered only if you have 20 or more employees enrolled for medical coverage. Medical benefits will be effective for retirees if approved by Quartz.

☐ Please attach a copy of your eligibility requirements for retiree coverage.

Indicate names of individuals: _____

Section E – Agent / Agency Information

☐ Direct Sale, skip the Agent of Record Information. Don't forget to sign the application.

☐ Agency Sale, please complete the Agent of Record Information. Don't forget to sign the application.

AGENT OF RECORD (Agent / Agency to receive commissions)

National Producer Number (NPN): Agency Name: Phone Number: ( )

You, the agent, certify that you have met with the Employer submitting this Application and that you have fully explained its contents. You have discussed coverage, eligibility, late enrollee delayed effective date, the effect of misrepresentations and terminations provisions.

Dated: _____ *(Month / Day / Year)*

Agent's Name: _____ *(Please Print)*

Agent's Signature: _____

Section F – Employer Agreement

Insurance coverage is not in effect unless and until you receive written notification from Quartz. UNDER NO CIRCUMSTANCES SHOULD YOU CANCEL YOUR PRESENT GROUP INSURANCE COVERAGE UNTIL YOU RECEIVE PRIOR WRITTEN NOTICE OF APPROVAL FROM QUARTZ.

If the Employer fails to pay its first month's premium within 31 days of its effective date, any claims Quartz paid in reliance of its contract with the Employer will be revoked.

As an authorized signor for this Employer, I have reviewed the Quartz Proposal and Required Notices, and accept the quoted rates on behalf of this Employer. I understand that total monthly premiums due are based on the current employee demographic information supplied to Quartz (including, but not limited to, the number of employees covered and their ages). Changes to this information may increase or decrease the total monthly premium. I understand this Employer's payment of first month's premium binds its Group Master Policy Agreement with Quartz. I further attest and certify that all statements included in this Application are true and correct to the best of my knowledge.

Dated on: _____
(Month / Day / Year)

Name: _____
(Print Employer Name)

Signature: _____
(Employer Signature)

Title: _____

Section G – Certification Required For CMS Section 111 Reporting

Below is a survey to help us determine how to correctly report group size to the Centers for Medicare and Medicaid Services (CMS) under Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007, and to also determine whether your group is considered a large or small group under Affordable Care Act regulations. Failure to accurately respond may result in penalties imposed by the federal government.

1. Is this a Multi-Employer Plan: ☐ Yes ☐ No
   When two or more employers are sponsors or contributors to a multiple employer plan and at least one of them has 20 or more full and / or part-time employees. For example, company ABC and company DEF purchase health insurance coverage together under the DEF company name.

2. Enter the average number of employees working at least 20 hours per week on business days during the preceding calendar year, excluding employees whose health coverage is determined by a collective bargaining agreement, and excluding individuals working on a temporary, seasonal or substitute basis. **The number of employees should not include retirees and disabled former employees required to be covered.* (include all locations): _____
   **Collective Bargaining Agreement: If the group insured is a collective bargaining unit, only count employees who are part of the collective bargaining unit. Do not count other employees in the company.*

3. Medicare Secondary Payer provisions apply to employers that have 20 or more full-time and / or part-time employees for each working day in each of 20 or more calendar weeks in the current or preceding year. When calculating your number of full-time and part-time employees you must use the total number of employees in your organizational structure including the parent company, subsidiaries, etc.
   ■ 2 – 19 employees ■ 20 or more employees

4. Medicare Secondary Payer disability provisions have a different rule for reporting group size for disabled employees. When calculating your number of full-time and part-time employees you must use the total number of employees in your organizational structure including the parent company, subsidiaries, etc. Did you employ 100 or more full-time and part-time employees on 50% or more of your regular business days during the previous calendar year?
   ☐ Yes ☐ No
   The Medicare Secondary Payer regulations as dictated by CMS require you to report any changes in employment during the course of the year that could impact your employer size determination related to the 20 employees or more requirements described above. In other words, you must notify us when you have had an increase to a size of 20 or more full-time and part-time employees for 20 or more weeks during the current calendar year.

5. COBRA applies to employers that employ 20 or more full-time and part-time employees on 50% of the business days during the preceding calendar year. Part-time employees count as a fraction of a full-time employee and should be counted in this manner.
   ■ 2 – 19 employees ■ 20 or more employees

Certification

I HEREBY CERTIFY that I have read the above statement and to the best of my knowledge and belief, it is a true, correct and complete statement prepared in accordance with the applicable instructions.

I attest that I have the authority to sign on behalf of the company represented in this survey. I agree that Quartz may use the email addresses provided in this document to contact the individuals listed in this document.

Signature: _____ Date: _____
(Officer / Owner or Group Contact's Signature Required) *(Month / Day / Year)*

Title: _____
(Please Print)

Employee Application
Minnesota Groups

Please Complete Entire Form in BLACK INK

Offered by Quartz Health Plan MN Corporation.
840 Carolina Street • Sauk City, WI 53583-1374
(800) 362-3310 • Fax (608) 643-2564
QuartzBenefits.com

I. EMPLOYEE INFORMATION (Please do not use abbreviations or nicknames on this application)

☐ New ☐ Change	Last Name	First Name	MI

Social Security Number or Tax ID Number
(SSN / TIN is required for IRS tax reporting regarding your health plan. It does not have any impact on your application or enrollment.) _____ _____ _____ — _____ _____ — _____ _____ _____ _____

Street Address	Apt. #	City	State	Zip Code	County
Mailing Address *(if different)*		**City**	**State**	**Zip Code**	**County**

Date of Birth *(mm/dd/yyyy)*	Sex	Marital Status
____/____/_____	☐ Male ☐ Female	☐ Single ☐ Divorced ☐ Married (date: ____/____/_____) ☐ Domestic Partnership (date: ____/____/_____)

Primary Phone #	Email Address:	Primary Care Clinic Name / Primary Care Clinic City
( )		_____ _____

Language. Preferred spoken and written.
Please check one:
☐ English
☐ Spanish
☐ Hmong
☐ German
☐ Chinese
☐ American Sign Language
☐ Other
(please specify)_____

Race. Defined as a person's identification with one or more social groups.
Please select all that apply:
☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Pacific Islander
☐ White
☐ Declines to answer
☐ Unavailable

Ethnicity. Refers to shared cultural characteristics such as language, ancestry, practices, and beliefs. For this application, Ethnicity is broken out into two categories: Hispanic or Latino and Not Hispanic or Latino.
Please check one:
☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Declines to answer
☐ Unavailable

Plan Requested: ☐ HMO _____ Group Number: _____ ☐ POS _____ Group Number: _____ ☐ PPO _____ Group Number: _____

Type of Coverage: ☐ Employee ☐ Employee and Spouse ☐ Employee and Child(ren) ☐ Family
☐ **WAIVING COVERAGE (skip to section V. Waiver of Group Coverage)**
If married and only selecting coverage for yourself, please complete **section V.** for your spouse / children.

Reason for Enrollment: (check appropriate box)
☐ New Hire
☐ Loss of Other Coverage*
☐ Open Enrollment
☐ Marriage (date: ____/____/_____)
☐ Domestic Partnership (date: ____/____/____)
☐ Birth (date: ____/____/_____)
☐ Adoption / Placement for Adoption (date: ____/____/_____)
☐ Add / Delete Dependents
☐ Part-Time to Full-Time Employment (date of change: ____/____/_____)
☐ COBRA / State Continuation
☐ Rehire (date: ____/____/_____)
☐ Return from layoff (date: ____/____/_____)
☐ Name Change / Address Change / PCP or NP Change
☐ Transfer to Retiree Segment
☐ Transfer to Disability Segment
☐ Other

By checking the box you are confirming your loss of other coverage entitles you to a Special Enrollment Period.

II. EMPLOYER INFORMATION

Name of Employer Group:	Date Employed:	Weekly Hours:	Requested Effective Date:
	____/____/_____		____/____/_____

Employment Status: ☐ Active ☐ Retired ☐ LOA
☐ COBRA / Continuation Effective Date ____/____/_____

COBRA Reason: ☐ End of Employment ☐ Reduction in Hours of Employment ☐ Death of Employee ☐ Divorce or Legal Separation ☐ Entitlement to Medicare ☐ Loss of Dependent Child Status

III. DEPENDENT INFORMATION – Please list all other members to be covered:

Dependent's Last Name | First Name | MI

Social Security Number or Tax ID Number
(SSN / TIN is required for IRS tax reporting regarding your health plan. It does not have any impact on your application or enrollment.)
___ ___ ___ — ___ ___ — ___ ___ ___ ___

Does Dependent live at the same address as you? ☐ Yes ☐ No If **No** list address:

Mailing Address ______________________________

Apt. # __________ City ______________________ State _____ Zip Code __________ County ______________

Relationship to you | Date of Birth *(mm/dd/yyyy)* ____/____/______ | Sex ☐ Male ☐ Female | Primary Care Clinic Name ______________ Primary Care Clinic City ______________

Language. Preferred spoken and written.
Please check one:
☐ English
☐ Spanish
☐ Hmong
☐ German
☐ Chinese
☐ American Sign Language
☐ Other
(please specify)____________________

Race. Defined as a person's identification with one or more social groups.
Please select all that apply:
☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Pacific Islander
☐ White
☐ Declines to answer
☐ Unavailable

Ethnicity. Refers to shared cultural characteristics such as language, ancestry, practices, and beliefs. For this application, Ethnicity is broken out into two categories: Hispanic or Latino and Not Hispanic or Latino.
Please check one:
☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Declines to answer
☐ Unavailable

Dependent's Last Name | First Name | MI

Social Security Number or Tax ID Number
(SSN / TIN is required for IRS tax reporting regarding your health plan. It does not have any impact on your application or enrollment.)
___ ___ ___ — ___ ___ — ___ ___ ___ ___

Does Dependent live at the same address as you? ☐ Yes ☐ No If **No** list address:

Mailing Address ______________________________

Apt. # __________ City ______________________ State _____ Zip Code __________ County ______________

Relationship to you | Date of Birth *(mm/dd/yyyy)* ____/____/______ | Sex ☐ Male ☐ Female | Primary Care Clinic Name ______________ Primary Care Clinic City ______________

Language. Preferred spoken and written.
Please check one:
☐ English
☐ Spanish
☐ Hmong
☐ German
☐ Chinese
☐ American Sign Language
☐ Other
(please specify)____________________

Race. Defined as a person's identification with one or more social groups.
Please select all that apply:
☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Pacific Islander
☐ White
☐ Declines to answer
☐ Unavailable

Ethnicity. Refers to shared cultural characteristics such as language, ancestry, practices, and beliefs. For this application, Ethnicity is broken out into two categories: Hispanic or Latino and Not Hispanic or Latino.
Please check one:
☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Declines to answer
☐ Unavailable

Dependent's Last Name | First Name | MI

Social Security Number or Tax ID Number
(SSN / TIN is required for IRS tax reporting regarding your health plan. It does not have any impact on your application or enrollment.)
___ ___ ___ — ___ ___ — ___ ___ ___ ___

Does Dependent live at the same address as you? ☐ Yes ☐ No If **No** list address:

Mailing Address ______________________________

Apt. # __________ City ______________________ State _____ Zip Code __________ County ______________

Relationship to you | Date of Birth *(mm/dd/yyyy)* ____/____/______ | Sex ☐ Male ☐ Female | Primary Care Clinic Name ______________ Primary Care Clinic City ______________

Language. Preferred spoken and written.
Please check one:
☐ English
☐ Spanish
☐ Hmong
☐ German
☐ Chinese
☐ American Sign Language
☐ Other
(please specify)____________________

Race. Defined as a person's identification with one or more social groups.
Please select all that apply:
☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Pacific Islander
☐ White
☐ Declines to answer
☐ Unavailable

Ethnicity. Refers to shared cultural characteristics such as language, ancestry, practices, and beliefs. For this application, Ethnicity is broken out into two categories: Hispanic or Latino and Not Hispanic or Latino.
Please check one:
☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Declines to answer
☐ Unavailable

III. DEPENDENT INFORMATION – Please list all other members to be covered:

Dependent's Last Name	First Name	MI

Social Security Number or Tax ID Number
(SSN / TIN is required for IRS tax reporting regarding your health plan. It does not have any impact on your application or enrollment.) ___ ___ ___ – ___ ___ – ___ ___ ___ ___

Does Dependent live at the same address as you? ☐ Yes ☐ No If **No** list address:

Mailing Address ______________________________

Apt. # __________ City ______________________ State _____ Zip Code __________ County ______________

Relationship to you	Date of Birth *(mm/dd/yyyy)* ____/____/________	Sex ☐ Male ☐ Female	Primary Care Clinic Name ______________ Primary Care Clinic City ______________

Language. Preferred spoken and written.
Please check one:
☐ English
☐ Spanish
☐ Hmong
☐ German
☐ Chinese
☐ American Sign Language
☐ Other
(please specify)____________________

Race. Defined as a person's identification with one or more social groups.
Please select all that apply:
☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Pacific Islander
☐ White
☐ Declines to answer
☐ Unavailable

Ethnicity. Refers to shared cultural characteristics such as language, ancestry, practices, and beliefs. For this application, Ethnicity is broken out into two categories: Hispanic or Latino and Not Hispanic or Latino.
Please check one:
☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Declines to answer
☐ Unavailable

Dependent's Last Name	First Name	MI

Social Security Number or Tax ID Number
(SSN / TIN is required for IRS tax reporting regarding your health plan. It does not have any impact on your application or enrollment.) ___ ___ ___ – ___ ___ – ___ ___ ___ ___

Does Dependent live at the same address as you? ☐ Yes ☐ No If **No** list address:

Mailing Address ______________________________

Apt. # __________ City ______________________ State _____ Zip Code __________ County ______________

Relationship to you	Date of Birth *(mm/dd/yyyy)* ____/____/________	Sex ☐ Male ☐ Female	Primary Care Clinic Name ______________ Primary Care Clinic City ______________

Language. Preferred spoken and written.
Please check one:
☐ English
☐ Spanish
☐ Hmong
☐ German
☐ Chinese
☐ American Sign Language
☐ Other
(please specify)____________________

Race. Defined as a person's identification with one or more social groups.
Please select all that apply:
☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Pacific Islander
☐ White
☐ Declines to answer
☐ Unavailable

Ethnicity. Refers to shared cultural characteristics such as language, ancestry, practices, and beliefs. For this application, Ethnicity is broken out into two categories: Hispanic or Latino and Not Hispanic or Latino.
Please check one:
☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Declines to answer
☐ Unavailable

Dependent's Last Name	First Name	MI

Social Security Number or Tax ID Number
(SSN / TIN is required for IRS tax reporting regarding your health plan. It does not have any impact on your application or enrollment.) ___ ___ ___ – ___ ___ – ___ ___ ___ ___

Does Dependent live at the same address as you? ☐ Yes ☐ No If **No** list address:

Mailing Address ______________________________

Apt. # __________ City ______________________ State _____ Zip Code __________ County ______________

Relationship to you	Date of Birth *(mm/dd/yyyy)* ____/____/________	Sex ☐ Male ☐ Female	Primary Care Clinic Name ______________ Primary Care Clinic City ______________

Language. Preferred spoken and written.
Please check one:
☐ English
☐ Spanish
☐ Hmong
☐ German
☐ Chinese
☐ American Sign Language
☐ Other
(please specify)____________________

Race. Defined as a person's identification with one or more social groups.
Please select all that apply:
☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Pacific Islander
☐ White
☐ Declines to answer
☐ Unavailable

Ethnicity. Refers to shared cultural characteristics such as language, ancestry, practices, and beliefs. For this application, Ethnicity is broken out into two categories: Hispanic or Latino and Not Hispanic or Latino.
Please check one:
☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Declines to answer
☐ Unavailable

IV. OTHER INSURANCE INFORMATION:

1. Are you or your spouse or child(ren) covered by Medicare (Parts A, B, C, or D)? ☐ Yes ☐ No
If yes, please list name(s):

Reason for Medicare: ☐ Age 65 ☐ Disability ☐ End Stage Renal Disease ☐ Disability and ESRD

Part A Effective Date: ____/____/_____ Part C Effective Date: ____/____/_____	Part B Effective Date: ____/____/_____ Part D Effective Date: ____/____/_____	Medicare Beneficiary Identifier (MBI): _____

2. Are you or any dependents listed above involved in a Workers' Compensation case? ☐ Yes ☐ No
If Yes, indicate who is involved and start date / accident date and insurance company name:

3. Will you or any of your dependents continue to have other insurance after the Quartz effective date of this policy? ☐ Yes ☐ No
If Yes, complete –

Names of those covered under policy	Employer	
Insurance Company	Subscriber #	Group #
Effective Date of Coverage	Insurance Company Phone # ( )	
Termination Date		

I acknowledge that I have read and completed the entire Application. If I received assistance in reading or completing this Application, I have identified the person(s) who assisted me.

I agree that the answers are, to the best of my knowledge and ability, complete and true. I understand that my answers, together with any supplements or additional pages, are the basis for the certificate or policy that is issued. I agree that no insurance will be effective until the date specified by the insurance company on the certificate or policy. I understand that any material misstatement or omission relied upon by the insurer may result in denial of claim and / or rescission of coverage. I further understand that this contract can be voided if within the first 24 months from the date of the policy or certificate it is determined that I or a dependent made an intentional misrepresentation in the application.

I understand that it may be a crime to submit an application or file a claim based on a false or deceptive statement. I further understand it may be a crime to submit an application that is intended to mislead an insurer or conceal significant information about the applicant.

I understand that I may request a copy of this Application and the notice of the company's privacy practices. I agree that a photocopy is as valid as an original. A legible facsimile or electronic signature shall have the same force as the original. I agree that Quartz may use the email addresses provided in this document to contact the individuals listed in this document.

I understand that enrollment and / or eligibility for benefits may be conditioned upon my willingness to provide written authorization permitting Quartz to obtain medical records from health care providers who have treated me, my spouse or any dependents applying for coverage under this application. If medical records are needed, Quartz will provide me with an authorization form.

DENTAL DISCLAIMER

This policy does not include pediatric dental services, which is an essential health benefit under the Affordable Care Act. This dental coverage is available in the insurance market as a stand-alone dental product. Please contact your insurance carrier, agent, Federally Facilitated Marketplace, or state-based Health Care Exchange if you wish to purchase pediatric dental coverage or a stand-alone dental product. By signing this application you are acknowledging this policy does not contain pediatric dental.

Applicant's Signature: _____ Date_____

V. WAIVER of GROUP COVERAGE:

I hereby elect **not** to apply for group health plan coverage. I hereby waive group health plan coverage for:

☐ Myself ☐ Spouse ☐ Children or other eligible dependents

Reason for waiving coverage –

☐ I / we will be covered under another health benefit plan that is not sponsored by my employer.

Name of Insurance Co.: _____

☐ Other reason for waiving: _____

I certify that I have been given the opportunity to apply for the Quartz group health benefit plan coverage for which I am eligible. I decline to enroll for such coverage as indicated above, on behalf of the persons listed above. I understand that I may be able to obtain coverage at a later time for reasons listed in the Notice of Special Enrollment Rights. If circumstances in the Notice of Special Enrollment Rights do not apply then I and / or the persons listed above may be able to apply for coverage at Open Enrollment.

I certify that the information above is, to the best of my knowledge and ability, complete and true.

Applicant's Signature: _____ Date_____

If you are electing coverage for yourself, please make sure you sign page 4 of the application.

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). 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. However, you must request enrollment within 31 days after the marriage. Payment of back premiums for newborns or newly-adopted children is required prior to claims payment.

Quartz

Non-Discrimination & Language Access

Quartz is the brand name for a group of companies committed to your health: Quartz Health Benefit Plans Corporation, Quartz Health Insurance Corporation, Quartz Health Plan Corporation, and Quartz Health Plan MN Corporation. These companies are separate legal entities. In this notice, "we" refers to all Quartz companies.

For assistance understanding these materials in a language other than English, call (800) 362-3310, and a Customer Service representative will assist you. TTY users should call 711 or (800) 877-8973.

We comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex.

We provide free aids and services to people with disabilities to communicate effectively with us, such as –

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

We provide free language services to people whose primary language is not English, such as –

- Qualified interpreter
- Information written in other languages

If you need these services, contact Customer Service at (800) 362-3310.

If you believe we failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with –

Kristie Meier, Compliance Officer
840 Carolina Street
Sauk City, WI 53583
Phone: (800) 362-3310
TTY: 711 or toll-free (800) 877-8973
Fax: (608) 644-3500
Email: AppealsSpecialists@quartzbenefits.com

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, Kristie Meier, Compliance Officer, is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
(800) 368-1019; (800) 537-7697 (TDD)

Complaint forms are available at hhs.gov/ocr/office/file/index.html

Quartz is a Qualified Health Plan issuer in the Health Insurance Marketplace in certain states. To learn more, visit the Health Insurance Marketplace at HealthCare.gov.

For help to translate or understand this, please call (800) 362-3310, TTY: 711 / (800) 877-8973.

Spanish – Este Aviso contiene información importante. Este aviso contiene información importante acerca de su solicitud o cobertura a través de Quartz. Preste atención a las fechas clave que contiene este aviso. Es posible que deba tomar alguna medida antes de determinadas fechas para mantener su cobertura médica o ayuda con los costos. Usted tiene derecho a recibir esta información y ayuda en su idioma sin costo alguno. Llame al (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

Hmong – Tsab ntawv tshaj xo no muaj cov ntshiab lus tseem ceeb. Tsab ntawv tshaj xo no muaj cov ntsiab lus tseem ceeb txog koj daim ntawv thov kev pab los yog koj qhov kev pab cuam los ntawm Quartz. Saib cov caij nyoog los yog tej hnub tseem ceeb uas sau rau hauv daim ntawv no kom zoo. Tej zaum koj kuj yuav tau ua qee yam uas peb kom koj ua tsis pub dhau cov caij nyoog uas teev tseg rau hauv daim ntawv no mas koj thiaj yuav tau txais kev pab cuam kho mob los yog kev pab them tej nqi kho mob ntawd. Koj muaj cai kom lawv muab cov ntshiab lus no uas tau muab sau ua koj hom lus pub dawb rau koj. Hu rau (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

Vietnamese – Thông báo này cung cấp thông tin quan trọng. Thông báo này có thông tin quan trọng bàn về đơn nộp hoặc hợp đồng bảo hiểm qua chương trình Quartz. Xin xem ngày then chốt trong thông báo này. Quý vị có thể phải thực hiện theo thông báo đúng trong thời hạn để duy trì bảo hiểm sức khỏe hoặc được trợ trúp thêm về chi phí. Quý vị có quyền được biết thông tin này và được trợ giúp bằng ngôn ngữ của mình miễn phí. Xin gọi số (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

Chinese – 本通知含有重要的訊息 本通知對於您透過 Quartz 所提 出的申請或保險有重要的訊息 請在本通知中查看重要的日期 您可能要在特定的截止日期之 前採取行動，以保留您的健康保險或有助於省錢 您有權利免費以您的母語得到幫助和訊息 請致電 (800) 362-3310：711 / (800) 877-8973.

Russian – Настоящее уведомление содержит важную информацию. Это уведомление содержит важную информацию о вашем заявлении или страховом покрытии через Quartz. Посмотрите на ключевые даты в настоящем уведомлении. Вам, возможно, потребуется принять меры к определенным предельным срокам для сохранения страхового покрытия или помощи с расходами. Вы имеете право на бесплатное получение этой информации и помощь на вашем языке. Звоните по телефону (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

Laotian – ແຈ້ງການສະບັບນີ້ມີຂໍ້ມູນທີ່ສຳຄັນ.
ແຈ້ງການສະບັບນີ້ມີຂໍ້ມູນທີ່ສຳຄັນກ່ຽວກັບໃບສະໝັກ ຫຼື ການຄຸ້ມຄອງຂອງທ່ານຜ່ານ Quartz. ຊອກຫາວັນທີສຳຄັນ ໃນໜັງສືແຈ້ງການສະບັບນີ້.ທ່ານອາດຈຳເປັນຕ້ອງປະຕິບັດຕາມເວລາ ທີ່ກຳນົດໄວ້ທີ່ແນ່ນອນເພື່ອຮັກສາໄວ້ການຄຸ້ມຄອງສຸຂະພາບຂອງທ່ານ ຫຼື ຊ່ວຍເຫຼືອດ້ານຄ່າໃຊ້ຈ່າຍ.ທ່ານມີສິດທີ່ຈະໄດ້ຮັບຂໍ້ມູນນີ້ ແລະ ຄວາມຊ່ວຍເຫຼືອໃນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ. ໂທຫາເບີ (800) 362 3310. TTY / TDD: 711 / (800) 877 8973.

German – Diese Benachrichtigung enthält wichtige Informationen. Diese Benachrichtigung enthält wichtige Informationen bezüglich Ihres Antrags auf Krankenversicherungsschutz durch Quartz. Suchen Sie nach wichtigen Terminen in dieser Benachrichtigung. Sie könnten bis zu bestimmten Stichtagen handeln müssen, um Ihren Krankenversicherungsschutz oder Hilfe mit den Kosten zu behalten. Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Rufen Sie an unter (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

Arabic – يحتوي هذا الإشعار على معلومات مهمة. يتضمن هذا الإشعار معلومات هامة حول طلبك أو تغطيتك عبر Quartz. ابحث عن التواريخ الرئيسية في هذا الإشعار. قد تحتاج إلى إجراء تدابير معيّنة وفقاً لمواعيد معيّنة من أجل الحفاظ على تغطيتك الصحية أو المساعدة في التكاليف. ليدك الحق في الحصول على هذه المعلومات وعلى المساعدة في لغتك دون أي تكلفة. اتصل على TTY / TDD: 711 / (800) 877-8973 / (800) 362-3310.

French – Cet avis a d'importantes informations. Cet avis a d'importantes informations sur votre demande ou la couverture par l'intermédiaire de Quartz. Rechercher les dates clés dans le présent avis. Vous devrez peut-être prendre des mesures par certains délais pour maintenir votre couverture de santé ou d'aide avec les coûts. Vous avez le droit d'obtenir cette information et de l'aide dans votre langue à aucun coût. Appelez (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

Korean – 본 통지서에는 중요한 정보가 들어 있습니다. 즉 이 통지서는 귀하의 신청에 관하여 그리고 Quartz을 통한 커버리지 에 관한 정보를 포함하고 있습니다.본 통지서에서 핵심이 되는 날짜들을 찾으십시오. 귀하는 귀하의 건강 커버리지를 계속유지하거나 비용을 절감하기 위해서 일정한 마감일까지 조치를 취해야 할 필요가 있을 수있습니다. 귀하는 이러한 정보와 도움을 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가있습니다. (800) 362-3310 로 전화하십시오. TTY / TDD: 711 / (800) 877-8973.

Tagalog – Ang Paunawa na ito ay naglalaman ng mahalagang impormasyon. Ang paunawa na ito ay naglalaman ng mahalagang impormasyon tungkol sa iyong aplikasyon o pagsakop sa pamamagitan ng Quartz. Tingnan ang mga mahalagang petsa dito sa paunawa. Maaring mangailangan ka na magsagawa ng hakbang sa ilang mga itinakdang panahon upang mapanatili ang iyong pagsakop sa kalusugan o tulong na walang gastos. May karapatan ka na makakuha ng ganitong impormasyon at tulong sa iyong wika ng walang gastos. Tumawag sa (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

Pennsylvanian Dutch – Die Bekanntmaching gebt wichdichi Auskunft. Die Bekanntmaching gebt wichdichi Auskunft baut dei Application oder Coverage mit Quartz. Geb Acht fer wichdiche Daadem in die Bekanntmachung. Es iss meeglich, ass du ebbes duh muscht, an beschtimmde Deadlines, so ass du dei Health Coverage bhalde kannscht, odder bezaahle helfe kannscht. Du hoscht es Recht fer die Information un Hilf in deinre eegne Schprooch griege, un die Hilf koschtet nix. Kannscht du (800) 362-3310 uffrufe. TTY / TDD: 711 / (800) 877-8973.

Polish – To ogłoszenie zawiera ważne informacje. To ogłoszenie zawiera ważne informacje odnośnie Państwa wniosku lub zakresu świadczeń poprzez Quartz.Prosimy zwrócic uwagę na kluczowe daty zawarte w tym ogłoszeniu aby nie przekroczyć terminów w przypadku utrzymania polisy ubezpieczeniowej lub pomocy związanej z kosztami. Macie Państwo prawo do bezpłatnej informacji we własnym języku. Zadzwońcie pod (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

Hindi – इस सूचना में महत्वपूर्ण जानकारी शामिल है। इस सूचना में Quartz से जुड़े आपके आवेदन या कवरेज के बारे में महत्वपूर्ण जानकारी शामिल है। इस सूचना में महत्वपूर्ण तारीखों को देखना न भूलें। स्वास्थ्य कवरेज जारी रखने या खर्चे में मदद के लिए आपको कुछ तय तारीखों तक कार्रवाई करनी ज़रूरी है। आपके पास अपनी भाषा में, बिना किसी शुल्क के इस जानकारी और सहायता को पाने का अधिकार है। (800) 362-3310. TTY / TDD: 711 / (800) 877-8973 पर कॉल करें।

Albanian – Ky njoftim përmban informacion të rëndësishëm. Ky njoftim përmban informacion të rëndësishëm për aplikimin ose mbulimin tuaj nëpërmjet Quartz. Kontrolloni për data të rëndësishme në këtë njoftim. Mund t'ju duhet të ndërmerrni veprim brenda afatave të caktuara për të mbajtur mbulimin tuaj shëndetësor ose për ndihmën me koston. Keni të drejtë ta merrni këtë informacion dhe ndihmë falas në gjuhën tuaj. Telefononi numrin (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

Somali – FIIRO GAAR AH: Haddii aad ku hadashid af Soomaali, adeegyada caawimada luuqada, ayaa waxaa laguugu siinayaa bilaash, waa laguu heli karaa. 1-800-362-3310 (TTY: 1-800-877-8973) bilbilaa.

Cushite – Oroomiffa XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

Amharic – ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ (800) 362-3310. (መስማት ለተሳናቸው: 711 / (800) 877-8973).

Karen – ဟ်သူဉ်ဟ်သး– နမ့်ကတိၤ ကညီ ကျိာ်အဃိ, နမၤနှ့ၢ် ကျိာ်အတၢ်မၤစၢၤလ၊ တလၢာ်ဘူဉ်လၢာ်စုၤ နီတမံၤဘဉ်သုနှဉ်လီၤ. ကိး (800) 362-3310.TTY / TDD: 711 / (800) 877-8973.

Mon-Khmer, Cambodian – ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

Serbocroatian – OBAVJEŠTENJE: Ako govorite srpskohrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite (800) 362-3310 TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711 / (800) 877-8973.

Thai – เรียน: ถา้ คุณพดู ภาษาไทยคุณสามารถใชบ้ ริการช่วยเหลือทางภาษาไดฟ้ รี โทร (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

Gujarati – સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

Urdu – خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

Italian – ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

Greek – ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.