Employee Application
Illinois Groups

Please Complete Entire Form in BLACK INK

Quartz

Offered by Quartz Health Plan 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)

Employee's Last Name	First Name	MI	Primary Language ☐ English ☐ Spanish ☐ Other : _____

Social Security Number or Tax ID Number (SSN / TIN is required for IRS tax reporting regarding your health plan.)

Mailing Address	City	State	Zip Code	County

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

Date of Birth (mm/dd/yyyy) _____ /_____ /_____	Gender ☐ M ☐ F	Marital Status ☐ Single ☐ Married/Partner in Civil Union ☐ Divorced ☐ Separated ☐ Widowed	Home Phone Number (_____) _____ Work Phone Number (_____) _____ Cell Phone Number (_____) _____

Height /Weight:	Email:

Plan: ☐ HMO_____ ☐ POS_____

Type of Coverage ☐ Employee ☐ Employee and Spouse/Partner in Civil Union ☐ Employee and Children ☐ Family
☐ **WAIVING COVERAGE (skip to section V. Waiver of Group Coverage)**

*Primary Care Physician (PCP) or Nurse Practitioner (NP) and Clinic	Current Patient
**Confirm your NP can be selected as a PCP at QuartzBenefits.com/findadoctor. If no PCP or NP preference, indicate "ASSIGN".*	☐ Yes ☐ No

II. EMPLOYER INFORMATION

Requested Effective Date of Coverage: _____/_____/_____

Date Employed: _____/_____/_____ Hours Employee Works Per Week on Average:

Employment Status: ☐ Active ☐ Retired ☐ Leave of Absence
☐ COBRA / Continuation Effective Date _____/_____/ _____
Reason: ☐ End of Employment ☐ Death of Employee ☐ Entitlement to Medicare
☐ Reduction in Hours of Employment ☐ Divorce or Legal Separation ☐ Loss of Dependent Child Status

Name of Employer Group:

City, State, Zip:

Employer Contact: Contact Email:

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

Dependent Name (Last, First, MI)	**Social Security or Tax ID Number** *(SSN / TIN is required for IRS tax reporting regarding your health plan.)*	**Relationship**	**Date of Birth** (mm/dd/yyyy)	**Gender**	**Height and Weight**	**Clinic and Primary Care Physician (PCP) or Nurse Practitioner (NP) Name** *Confirm your NP can be selected as a PCP at QuartzBenefits.com/findadoctor. If no PCP or NP preference, indicate "ASSIGN".*	**Current Patient?**
				☐ M ☐ F			☐ Yes ☐ No
				☐ M ☐ F			☐ Yes ☐ No
				☐ M ☐ F			☐ Yes ☐ No
				☐ M ☐ F			☐ Yes ☐ No
				☐ M ☐ F			☐ Yes ☐ No

Note: If you are waiving your right to this group coverage, you do not need to complete the General Information and Medical Information.

IV. GENERAL INFORMATION AND MEDICAL INFORMATION

1. Have you or any dependent ever been insured by Quartz? ☐ Yes ☐ No

   If yes, give subscriber name_____ Dates previously covered by Quartz _____

2. 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 the following information:

   Name(s) of Insured _____ Employer _____

   Insurance Company _____ Insurance Company Phone # _____

   Subscriber # _____ Group # _____

   Effective Date of Coverage _____

3. Are you or any family member(s) enrolled in Medicare? ☐ Yes ☐ No

   If yes, please answer the following and attach a copy of your Medicare Card.

   Name _____ Name _____

   Medicare # _____ Medicare # _____

   Effective Date, Part A _____ Effective Date, Part A _____

   Effective Date, Part B _____ Effective Date, Part B _____

   Effective Date, Part C *(Medicare Advantage)* _____ Effective Date, Part C *(Medicare Advantage)* _____

   Effective Date, Part D _____ Effective Date, Part D _____

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

4. Are you or any dependent now disabled or unable to perform normal activities? ☐ Yes ☐ No

   If yes, Name of person _____ Type of disability _____ Date of disability_____

5. Have you or any dependent incurred health claims in excess of $5,000 during the last 24 months? ☐ Yes ☐ No

   If yes, Name of person _____ Reason_____

6. Within the last 24 months have you or any dependent listed above consulted about, received treatment for or been diagnosed with: cancer, stroke, diabetes, heart condition (including hypertension), vascular disease, behavioral health (mental, anxiety or emotional disorder), muscular or systemic disease (such as arthritis or lupus), alcohol or drug use, liver, kidney, lung (such as COPD or asthma) or intestinal disorder? ☐ Yes ☐ No

   If yes, please explain on a separate sheet of paper and attach to this form. (You do not need to report genetic tests or test results.)

7. Have you ever been diagnosed by a member of the medical profession as having an immune system disorder, AIDS or ARC? ☐ Yes ☐ No

   (You do not need to report HIV test results. You only need to report testing, diagnosis, or treatment done by a physician or an appropriately licensed clinical professional acting within the scope of his/her license.)

8. Are you or any dependents currently taking any medications? ☐ Yes ☐ No

   If yes, please list the medications : _____

   _____

9. Are you or is any dependent listed above pregnant? Have you or has any listed dependent scheduled or had any surgeries in the last 12 months?

   Have you or has any listed dependent been hospitalized in the last 12 months? ☐ Yes ☐ No

   If Yes, Name(s) _____ Pregnancy Due Date _____

   Reason for hospitalization or surgery:_____

10. Are you or any dependents listed above involved in a Workers Compensation case? ☐ Yes ☐ No

    If Yes, indicate family member involved and start date / accident date: _____

    Workers Compensation Condition: _____

    Insurance Company Name: _____

    Insurance Company Address: *(where claim is sent)* _____

    Insurance Company Phone: _____

    Group#: _____

    Effective Date:_____ Term Date (if applicable): _____

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/partner in civil union or any dependents applying for coverage under this application. If medical records are needed, Quartz will provide me with an authorization form.

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/Partner in Civil Union ☐ 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.: _____

☐ I would have to pay more than 10 percent of my annualized gross income towards health insurance

☐ 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 me and/or the persons listed above may be able to apply for coverage at Open Enrollment, if my employer has an Open Enrollment Period.

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

Applicant's Signature: _____ Date_____

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse/partner in civil union) 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, birth, adoption, or placement for adoption.