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.

<table>
<thead>
<tr>
<th>Eligible Employees*</th>
<th>Participating Employees*</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 – 4</td>
<td>1</td>
</tr>
<tr>
<td>5 – 6</td>
<td>3</td>
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<td>7</td>
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<td>10</td>
<td>6</td>
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<td>11+</td>
<td>70 percent</td>
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</tbody>
</table>

* Note: The limits will be strictly enforced.

* 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.

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.
### Section A – General Employer Information

1. **Exact Legal Name of Employer (Policyholder):**
   - Federal Tax ID: 
   - Name of d / b / a (doing business as): 

2. **Street Address:**
   - City: 
   - State: 
   - Zip Code: 

3. **Mailing Address:**
   - City: 
   - State: 
   - Zip Code: 

4. **County of primary location:**
   - Phone Number: ( )
   - Fax Number: ( )

5. **Owner Name(s):**
   - % Owner(s): 

6. **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:

7. **Parent Company, if any:**
   - Parent Company Federal Tax ID: 
   - Number of employees at Parent Company including all subsidiaries:

8. **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:

9. **Is this coverage part of a union negotiated agreement?**
   - ☐ Yes
   - ☐ No
   - If Yes, Expiration Date:

10. **Nature of Business:**

11. **How long has your company been in business?**

12. **Employer Group Contact Name:**
   - Title: 
   - Phone: ( )
   - Email*: 

*Please note that there is a billing charge if you do not provide an email address for electronic billing.

For groups with 1 - 50 employees, please attach your Quarterly Wage and Tax Form: Worker’s Compensation Quarterly Report or Unemployment Compensation Report – Form UC 101.
Section B – Plan Information

1. Requested effective date:  
(COVERAGE IS NOT EFFECTIVE UNTIL WE NOTIFY YOU IN WRITING)

2. Our default hourly requirement for employee eligibility is 30 hours per week. You may reduce the hourly requirement for eligibility if your hourly requirement is not less than 20 hours per week. State your hourly requirement for health plan eligibility:  
_______ hours per week (May not exceed 30 hours).

3. Total number of permanent active employees currently on payroll:
   Total number of employees on payroll eligible for coverage (based on hourly requirement in question 2):
   Total number of employees not eligible for coverage (e.g. seasonal or part-time employees):
   Total number of employees enrolling for coverage:
   Total number of employees waiving coverage:

4. 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:

5. Name of Workers’ Compensation Carrier:
   If your company is exempt from state workers’ compensation requirements, check here:  ☐

6. Are you requesting Quartz bill COBRA members directly?  
☐ Yes  ☐ No
   If Yes, group’s COBRA notice must provide for a 30-day grace period for premium payments.

7. Are you applying for replacement of your current group medical coverage?  
☐ Yes  ☐ No
   If Yes, you must furnish the following information:
   a. Name of current group carrier:
   b. Original effective date:
   c. Attach your most recent billing statement.

8. Percent of medical insurance premium paid by Employer:
   Single: ______________%  (Minimum Requirement for Small Groups is 50%)
   Family: ______________%

9. Are you requesting a Health Reimbursement Account?  
☐ Yes  ☐ No  If yes, name of vendor:

10. Probationary Period for new employees (May not exceed 90 calendar days)
    _______ First of the month following:
    ☐ 0 days  ☐ 30 days  ☐ 60 days  ☐ Other
    OR
    _______ Immediately following:
    ☐ 0 days  ☐ 30 days  ☐ 60 days  ☐ 90 days  ☐ Other

11. Is the probationary period the same as listed in question 10 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:  ☐ Yes  ☐ No  If no, please explain eligibility guidelines:
    Return from layoff:  ☐ 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

12. Only for groups with more than 50 total employees:
    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.
    Do you have variable hour employees?  ☐ Yes  ☐ No
    If yes, please explain eligibility guidelines:
    Are you requesting domestic partner coverage?  ☐ Yes  ☐ No

Section C – 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.

Age: _______  Years of Service: _______  Classification: __________________________  ☐ Check if supplemental retiree language is provided
Section D – Plan Selection

1. BENEFIT PLAN: ☐ HMO ☐ POS – Jointly offered by Quartz Health Benefit Plans Corporation and Quartz Health Insurance Corporation

2. For Groups under 50 employees:
   Plan Name: ________________________________
   Please write in the plan name exactly how it appears on the rate sheet.

Section E – 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: ___________________________  By: ___________________________
   (Month / Day / Year)  (Print Employer Name)

By: ___________________________
   (Employer Signature)

Title: ___________________________

Section F – 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: (_______)  Fax Number: (_______)

Street: ___________________________  City: ___________________________  State: ___________________________  Zip Code: ___________________________

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: ___________________________  Agent’s Name: ___________________________
   (Month / Day / Year)  (Please Print)

   Agent’s Signature: ___________________________

AGENT CHECK LIST:

☐ Schedule of Benefits  ☐ Applicable Riders  ☐ Employee Applications and Waivers  ☐ Current Prior Carrier Statement

☐ Small Employer Renewability and Rating Notice  ☐ Quarterly Wage & Tax Form  ☐ Rate Proposal

Comments:

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________
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 full, part-time, and seasonal employees employed during the preceding calendar year (include all locations): ________________

   *If you have a parent/brother/sister company or subsidiaries, please refer to Illinois Statutes Section 215 ILCS 97/5 to determine whether you may be treated as a single employer.

3. Did your company employ 100 or more employees (including full, part-time and seasonal) for 50 percent or more of your business days in the preceding calendar year?
   ☐ Yes (skip questions 4 and 5) ☐ No (go to question 4)

4. Did your company employ 20 or more employees (full, part-time, and seasonal) for more than 20 weeks in the preceding calendar year? (Note: 20 weeks do not have to be consecutive)
   ☐ Yes (go to question 5) ☐ No (skip question 5)

5. Please indicate the date your company first had 20 or more employees (full, part-time and seasonal) for more than 20 weeks in the preceding calendar year. If your company has always had more than 20 employees, please use 01/01 as your response.
   Enter the average number of employees that your company employed for the 20 weeks that your company had 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)

Company Contact Name: ___________________________

Phone Number: ___________________________
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 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
Office for Civil Rights
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 ntaww tshaj xo no muaj cov ntshiab lus tseem ceeb. Tsab ntaww tshaj xo no muaj cov ntshiab lus tseem ceeb borg koh jaij ntaww thov kev paw los yog koh ghov kev paw cuam los ntaww Quartz. Saib cov caij nyoog los yog tej hnub tseem ceeb uas sau rau hauv daim ntaww no kom zoo. Tej zaum koh juj yuav tau ua qee yam uas peb kom koh ua tsiis pub dhaau cov caij nyoog uas teev tseg rau hauv daim ntaww no mas koh thajj yuav tau txais kev paw cuam kho mob los yog kev paw them tej nqi kho mob ntaww. Koj muaj cai kom lawv muaj cov ntshiab lus no uas tau muab sau uas koh hajj lus pub dawb rau kohj. Hu rau (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.


Chinese – 通知您重要的訊息。通知您透過 Quartz 所提供的申請或保險有重要的訊息。請在通知中查看重要的日期。您可能要在特定的截止日期前採取行動，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 – ວຽກນັກຂ້າງມີຜິດການມີຊ່ວຍເຫຼືອການສະບັບ ຄ່າວງການຂ້າງມີຜິດການມີຊ່ວຍເຫຼືອການສະບັບ Quartz. ມີຜິດການມີຊ່ວຍເຫຼືອການສະບັບ Quartz ໃນຄ່າວງນັກຂ້າງມີຜິດການມີຊ່ວຍເຫຼືອການສະບັບ Quartz ຈອງປະກວດການສະບັບ Quartz ໃນຄ່າວງນັກຂ້າງມີຜິດການມີຊ່ວຍເຫຼືອການສະບັບ Quartz. ປະກວດການສະບັບ Quartz ຈອງປະກວດການສະບັບ Quartz ໃນຄ່າວງນັກຂ້າງມີຜິດການມີຊ່ວຍເຫຼືອການສະບັບ Quartz ໃນຄ່າວງນັກຂ້າງມີຜິດການມີຊ່ວຍເຫຼືອການສະບັບ Quartz ໃນຄ່າວງນັກຂ້າງມີຜິດການມີຊ່ວຍເຫຼືອການສະບັບ Quartz ໃນຄ່າວງນັກຂ້າງມີຜິດການມີຊ່ວຍເຫຼືອການສະບັບ Quartz ໃນຄ່າວງນັກຂ້າງມີຜິດການມີຊ່ວຍເຫຼືອການສະບັບ Quartz ໃນຄ່າວງນັກຂ້າງມີຜິດການມີຊ່ວຍເຫຼືອການສະບັບ Quartz ໃນຄ່າວງນັກຂ້າງມີຜິດການມີຊ່ວຍເຫຼືອການສະບັບ Quartz ໃນຄ່າວງນັກຂ້າງມີຜິດການມີຊ່ວຍເຫຼືອການສະບັບ Quartz ໃນຄ່າວງນັກຂ້າງມີຜິດການມີຊ່ວຍເຫຼືອການສະບັບ Quartz ໃນຄ່າວງນັກຂ້າງມີຜິດການມີຊ່ວຍເຫຼືອການສະບັບ Quartz ໃນຄ່າວງນັກຂ້າງມີຜິດການມີຊ່ວຍເຫຼືອການສະບັບ Quartz ໃນຄ່າວງນັກຂ້າງມີຜິດການມີຊ່ວຍເຫຼືອການສະບັບ Quartz ໃນຄ່າວງນັກຂ້າງມີຜິດການມີຊ່ວຍເຫຼືອການສະບັບ Quartz ໃນຄ່າວງນັກຂ້າງມີຜິດການມີຊ່ວຍເຫຼືອການສະບັບ Quartz ໃນຄ່າວງນັກຂ້າງມີຜິດການມີຊ່ວຍເຫຼືອການສະບັບ Quartz ໃນຄ່າວງນັກຂ້າງມີຜິດການມີຊ່ວຍເຫຼືອການສະບັບ Quartz ໃນຄ່າວງນັກຂ້າງມີຜິດການມີຊ່ວຍເຫຼືອ gf.gov (800) 362-3310. TTY / TDD: 711 / (800) 877 8973.