

Individual Insurance Election Form – Beloit One Network



The plans below are only offered if you reside in Rock county. If you reside outside Rock county, please contact Quartz to see plans offered in your service area.

Offered by:
Quartz Health Benefit Plans Corporation

840 Carolina Street • Sauk City, WI 53583-1374
(800) 362-3310 • (608) 644-3430
Fax (608) 643-2564 • QuartzBenefits.com

In order to enroll for Quartz individual insurance coverage, you will need to complete the Applicant Information and the Individual Insurance Election Form

Requested Coverage Effective Date ____/____/____

1. Plan Options: (Please select a Plan Type and Dental Option)

PLAN TYPE					
PLAN NAME	Gold	Silver	Bronze	Catastrophic	
<input type="checkbox"/>	Gold HSA 2000*	<input type="checkbox"/>	Silver HSA 5250*	<input type="checkbox"/>	Bronze HSA 6750*
<input type="checkbox"/>	Gold HSA 3000*	<input type="checkbox"/>	Silver 4000 - Copay \$45/\$90	<input type="checkbox"/>	Bronze 7500 - Copay \$80/\$160
<input type="checkbox"/>	Gold 2000 - Copay \$30/\$70	<input type="checkbox"/>	Silver 5000 - Copay \$50/\$100	<input type="checkbox"/>	Bronze 7900 - Copay \$50/\$100
<input type="checkbox"/>	Gold Maintenance - Copay \$40/\$90	<input type="checkbox"/>	Silver 7900 - Copay \$80/\$160	<input type="checkbox"/> Catastrophic*	

Only individuals under 30 years old or with a hardship exemption qualify for Catastrophic Plans.

* The family dental option is not available.

Is this a child-only policy? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, are you the legal guardian or custodial parent? <input type="checkbox"/> Yes <input type="checkbox"/> No
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DENTAL OPTION	
<input type="checkbox"/> No – This policy does not include pediatric dental services as required under the federal Patient Protection and Affordable Care Act. This coverage is available in the insurance market and can be purchased as a standalone product. Please contact your insurance carrier, agent or the Federally Facilitated Exchange if you wish to purchase pediatric dental coverage or a stand-alone dental services product.	<input type="checkbox"/> Yes - I'd like to elect dental coverage for all members of my policy.
<input type="checkbox"/> By checking this box I acknowledge I am electing coverage that does not include pediatric dental services as required under the federal Patient Protection and Affordable Care Act. I have purchased an Exchange certified stand-alone dental plan.	

For plan descriptions, please visit QuartzBenefits.com or call Quartz Customer Service at (800) 362-3310.

2. Primary Care Physician (PCP) and Clinic – If there is not enough space provided, please attach information for any additional applicants on a separate page.

	Name (First, MI, Last)	Primary Care Physician (PCP) and Clinic	Are You A Current Patient?
Applicant			<input type="checkbox"/> Yes <input type="checkbox"/> No
Person 2			<input type="checkbox"/> Yes <input type="checkbox"/> No
Person 3			<input type="checkbox"/> Yes <input type="checkbox"/> No
Person 4			<input type="checkbox"/> Yes <input type="checkbox"/> No

3. Enrollment Reason – NOTE: Additional documentation may be required.

Open Enrollment

Special Enrollment Event Date ____/____/____

Please Select One:

Loss of Other Coverage (including COBRA) Prior Carrier Name: _____ Phone Number: _____

I attest that I did not lose coverage due to non-payment of premium or voluntary termination during my plan year.

Permanent Move Prior Carrier Name: _____ Phone Number: _____

Loss of Other Coverage due to failure to pay premium Birth / Adoption / Foster Care Marital Status Change

Change in Eligibility for Tax Credits or Cost-Sharing Reductions Other _____

4. Other Insurance Information

Does anyone applying for coverage currently have other health insurance, including Medicare? Yes No If yes, please fill in your insurance information below:

Current Insurance Provider: _____ Phone Number: _____

Policyholder: _____

List all individuals covered under this policy: _____

Member ID Number(s): _____

Termination Date (if applicable): _____

5. Invoice and Payment Options

You will receive a mailed paper invoice. If you would prefer to receive your invoice electronically, please visit QuartzMyChart.com. You can also arrange one-time or recurring Automated Clearing House (ACH) payments through MyChart. Other acceptable methods of payment include paper checks, cashier's checks, money orders, ACH, credit cards and all general-purpose pre-paid debit cards.

Applicant's Full Name (Please print): _____ Date: _____

Applicant's Signature: _____

Quartz is a Qualified Health Plan issuer in the Health Insurance Marketplace.

Quartz does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation, or health status in the administration of the plan, including enrollment and benefit determinations.

Applicant Information



All fields are required in order for an application to be considered for enrollment.

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STEP 1: Tell us about yourself.

(We'll need one adult in the family to be the contact person for your application.)

1. First Name, Middle Name, Last Name and Suffix:

2. Home Address:

3. Apartment or Suite Number:

4. City:

5. State:

6. ZIP Code:

7. County:

8. Mailing Address (if different from home address):

9. Apartment or Suite Number:

10. City:

11. State:

12. ZIP Code:

13. County:

14. Phone Number:

15. Other Phone Number:

16. E-mail Address:

17. Preferred spoken or written language (if not English):

18. Do you need health coverage?

Yes No

If **yes**, answer all the questions below.

If **no**, skip to Step 2 on page 4. (Leave the rest of this page blank)

19. Social Security Number or Taxpayer Identification Number (TIN):

_____ - _____ - _____

20. Sex:

Male Female

21. Date of Birth (mm/dd/yyyy):

____/____/____

22. Do you use tobacco (required if age 18+)? Yes No

Tobacco use is defined as use of tobacco on average of four or more times per week in the past six months.

NOW, tell us who else needs health coverage.

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STEP 2: Tell us about anyone else who needs health coverage.

(If you have more people to include, make a copy of this page and attach.)

STEP 2: PERSON 2

1. First Name, Middle Name, Last Name and Suffix:		2. Relationship to you:	
3. Social Security Number or Taxpayer Identification Number (TIN): _____ - _____ - _____	4. Date of Birth (mm/dd/yyyy): ____/____/____	5. Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
6. Does Person 2 live at the same address as you? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, list address:			
7. Does Person 2 use tobacco (required if age 18+)? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Tobacco use is defined as use of tobacco on average of four or more times per week in the past six months.</i>			

STEP 2: PERSON 3

1. First Name, Middle Name, Last Name and Suffix:		2. Relationship to you:	
3. Social Security Number or Taxpayer Identification Number (TIN): _____ - _____ - _____	4. Date of Birth (mm/dd/yyyy): ____/____/____	5. Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
6. Does Person 3 live at the same address as you? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, list address:			
7. Does Person 3 use tobacco (required if age 18+)? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Tobacco use is defined as use of tobacco on average of four or more times per week in the past six months.</i>			

STEP 2: PERSON 4

1. First Name, Middle Name, Last Name and Suffix:		2. Relationship to you:	
3. Social Security Number or Taxpayer Identification Number (TIN): _____ - _____ - _____	4. Date of Birth (mm/dd/yyyy): ____/____/____	5. Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
6. Does Person 4 live at the same address as you? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, list address:			
7. Does Person 4 use tobacco (required if age 18+)? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Tobacco use is defined as use of tobacco on average of four or more times per week in the past six months.</i>			

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STEP 3: Read and sign this application.

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 intentional misrepresentation relied upon by the insurer may be used to deny a claim. 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 family member 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 understand that I must pay all outstanding amounts owed for premiums to Quartz for the last 12 months in order for coverage to become effective.

Signature: _____ Date Signed: _____

STEP 4: Mail or E-mail your completed application.

Mail your completed application to:

Quartz - Sales Department
840 Carolina St.
Sauk City, WI 53583

Scan and E-mail your completed application to:

IndividualSales@QuartzBenefits.com

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STEP 5: Please sign the Notice to Applicant.

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

According to the information furnished by you on your application for insurance coverage, you intend to lapse or otherwise terminate your present policy and replace it with a policy to be issued by Quartz. For your own information and protection, certain facts should be pointed out to you which should be considered before you make this change.

1. Questions in the application for the new policy must be answered truthfully and completely; otherwise, the validity of the policy and the payment of any benefits thereunder may be voided.
2. The new policy will be issued at a higher age than that used for issuance of your present policy; therefore, the cost of the new policy, depending upon the benefits, may be higher than you are paying for your present policy.
3. The renewal provisions of the new policy should be reviewed so as to make sure of your rights to periodically renew the policy.
4. It may be to your advantage to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. You should be certain that you understand all the relevant factors involved in replacing your present coverage.

The above "Notice to Applicant" was delivered to me on _____.
(Date)

(Signature of Applicant)

Printed Name of Agent: _____ Date: _____

Agency Name: _____ National Producer Number: _____

Signature of Agent: _____

PLEASE KEEP A COPY OF THIS NOTICE FOR YOUR FILES.

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STEP 6: Assistance with Completing this Application (if applicable)

YOU CAN CHOOSE AN AUTHORIZED REPRESENTATIVE.

You can give a trusted person permission to talk about this application with us, see your application and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative." If you ever need to change your authorized representative, contact us. If you're a legally appointed representative for someone on this application, submit proof with the application.

1. First Name, Middle Name, Last Name and Suffix:

2. Address:

3. Apartment or Suite Number:

4. City:

5. State:

6. ZIP Code:

7. Phone Number:

8. Organization Name:

9. ID Number (If applicable)

By signing, you allow this person to sign your application, get official information about this application and act for you on all future matters with this agency.

10. Signature

11. Date (mm/dd/yyyy)

____/____/____

FOR CERTIFIED APPLICATION COUNSELORS, NAVIGATORS, AGENTS AND BROKERS ONLY.

Complete this section if you're a certified counselor, navigator, agent or broker filling out this application for somebody else.

1. Application Start Date (mm/dd/yyyy)

2. First name, Middle name, Last name and Suffix:

4. Organization Name:

4. ID Number (if applicable)



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 – Tsaab ntawv tshaj xo no muaj cov ntshiab lus tseem ceeb. Tsaab 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 bản về đơn nộp hoặc hợp đồng bảo hiểm qua chương trình Quartz. Xin xem ngay 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 giúp 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. ແຈ້ງການສະບັບນີ້ມີຂໍ້ມູນທີ່ສໍາຄັນກ່ຽວກັບໃບສະໜັກ ຫຼື ການຄຸ້ມຄອງຂອງທ່ານຜ່ານ Quartz. ຊອກຫາວັນທີ່ສໍາຄັນໃນຫນັງສືແຈ້ງການສະບັບນີ້. ທ່ານອາດຈຳເປັນຕ້ອງປະຕິບັດຕາມເວລາທີ່ກຳນົດໄວ້ທີ່ແນ່ນອນເພື່ອຮັກສາໄວ້ການຄຸ້ມຄອງສະພາບຂອງທ່ານ ຫຼື ຊ່ວຍເຫຼືອດ້ານຄ່າໃຊ້ຈ່າຍ. ທ່ານມີສິດທີ່ຈະໄດ້ຮັບຂໍ້ມູນນີ້ ແລະ ຄວາມຊ່ວຍເຫຼືອໃນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ. ໂທຫາເບີ (800) 362 3310. TTY / TDD: 711 / (800) 877 8973.

