

Employee Application Wisconsin Groups



Underwritten by
Unity Health Plans Insurance Corporation

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QuartzBenefits.com

Please Complete Entire Form in **BLACK INK**

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

Employee's Last Name		First Name		MI	Primary Language <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> 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
Date of Birth (mm/dd/yyyy) ____/____/____	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed		Home Phone Number (____) _____ Work Phone Number (____) _____ Cell Phone Number (____) _____		
Height /Weight:		Email:				
Plan: <input type="checkbox"/> HMO _____ <input type="checkbox"/> POS _____ <input type="checkbox"/> PPO _____						
Type of Coverage <input type="checkbox"/> Employee <input type="checkbox"/> Employee and Spouse <input type="checkbox"/> Employee and Children <input type="checkbox"/> Family <input type="checkbox"/> WAIVING COVERAGE (skip to section V. Waiver of Group Coverage)						
*Primary Care Physician (PCP) or Nurse Practitioner (NP) and Clinic *Confirm your NP can be selected as a PCP at QuartzBenefits.com/findadoctor. If no PCP or NP preference, indicate "ASSIGN".						Current Patient <input type="checkbox"/> Yes <input type="checkbox"/> No

II. EMPLOYER INFORMATION

Requested Effective Date of Coverage: ____/____/____	
Date Employed: ____/____/____ Hours Employee Works Per Week on Average: _____	
Employment Status: <input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> Leave of Absence <input type="checkbox"/> COBRA / Continuation Effective Date ____/____/____	
Reason: <input type="checkbox"/> End of Employment <input type="checkbox"/> Death of Employee <input type="checkbox"/> Entitlement to Medicare <input type="checkbox"/> Reduction in Hours of Employment <input type="checkbox"/> Divorce or Legal Separation <input type="checkbox"/> 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?
				<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Yes <input type="checkbox"/> 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.)

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 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 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 considered Late Applicants subject to either a 12 month delayed effective date, or, if my employer has an Open Enrollment Period, 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 _____

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, birth, adoption, or placement for adoption.