Illinois Employer Group Application

☐ New Group

☐ Renewing Group / Change*

Offered by Quartz Health Plan 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.

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

** 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.**

CONTINUE to the next page.

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.	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:			
6.	Parent Company, if any:			
	Parent Company Federal Tax ID:	Number of employees at Parent Company including all subsidiaries:		
7.	Do you want coverage for any subsidiaries? ☐ Yes ☐ No			
	a. If Yes, give legal name and address of each:			
	b. If No, give legal name and address of each affiliate not included and identify number of employees and insurance carrier for each:			
8.	Is this coverage part of a union negotiated agreement? ☐ Yes ☐ No	If Yes, Expiration Date:		
9.	Nature of Business:			
10.	How long has your company been in business?			
11.	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 - 100] employees, please attach your Quarterly Wage and Tax Form: Worker's Compensation Quarterly Report or Unemployment Compensation Report – Form UC 101.

CONTINUE to the next page.

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: 1.) you are enrolling at least 10 employees; and 2.) 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 the 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: _____% Family: _____%
9.	Are you requesting Annual Open Enrollment? ☐ Yes ☐ No If yes, Annual Open Enrollment Period:
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:**
12.	**Groups with more than 50 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

CONTINUE to the next page.

Section D – Plan Selection

1. BENEFIT PLAN: ☐ HMO ☐ POS

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

By: _____ **(Print Employer Name)**

By: _____ *(Employer Signature)*

Title: _____

Dated at: _____ *(City and State)*

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: _____ *(Month / Day / Year)*

Agent's Name: _____ *(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:

CONTINUE to the next page.

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. County where the Company's primary location is: _____ (i.e.: Winnebago, Stephenson County, etc.)

2. Employer Identification Number (Tax ID):

Subsidiary Name	Tax ID for Covered Subsidiary (Use additional pages if needed)

3. 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.

4) Enter the average number of full, part-time, and seasonal employees employed during calendar year 2018 (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*

5) Did your company employ 100 or more employees (including full, part-time and seasonal) for 50 percent or more of your business days in calendar year 2018?
☐ Yes (skip questions 6 and 7) ☐ No (go to question 6)

6) Did your company employ 20 or more employees (full, part-time, and seasonal) for more than 20 weeks in calendar year 2018? (Note: 20 weeks do not have to be consecutive)
☐ No (skip question 7) ☐ Yes (go to question 7)

7) Please indicate the date your company first had 20 or more employees (full, part-time and seasonal) for more than 20 weeks in the calendar year 2018. _____
(Month / Day)

Enter the average number of employees for the 20 weeks that your company had 20 or more employees for 2018. _____

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: _____

Quartz

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