

# Employee Application Illinois Groups



Offered by Gundersen Health Plan, Inc.

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

**QuartzBenefits.com**

**Please Complete Entire Form in BLACK INK**

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

<input type="checkbox"/> New <input type="checkbox"/> Change	Employee's Last Name	First Name	MI
Social Security Number or Tax ID Number <small>(SSN / TIN is required for IRS tax reporting regarding your health plan.)</small>			
Street Address	Apt. #	City	State Zip Code County
Street Address (if different)		City	State Zip Code County
Date of Birth (mm/dd/yyyy) ____/____/____	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married, Civil Union, Domestic Partnership (date: ____/____/____)	Primary Language Spoken <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____
Home Phone # ( )		Work Phone # ( )	
Cell Phone # ( )		Applicant's E-Mail Address:	
Plan Requested:	<input type="checkbox"/> HMO _____	<input type="checkbox"/> POS _____	
	Group Number: _____	Group Number: _____	
Type of Coverage:	<input type="checkbox"/> Employee	<input type="checkbox"/> Employee and Spouse or partner in civil union	<input type="checkbox"/> Employee and Child(ren) <input type="checkbox"/> Family
	<input type="checkbox"/> <b>WAIVING COVERAGE (skip to section V. Waiver of Group Coverage)</b>		
<b>Reason for Enrollment:</b> (check appropriate box)			
<input type="checkbox"/> New Hire	<input type="checkbox"/> Add / Delete Dependents	<input type="checkbox"/> Name Change / Address Change / PCP or NP Change	
<input type="checkbox"/> Loss of Other Coverage*	<input type="checkbox"/> Part-Time to Full-Time Employment (date of change: ____/____/____)	<input type="checkbox"/> Transfer to Retiree Segment	
<input type="checkbox"/> Open Enrollment	<input type="checkbox"/> COBRA / State Continuation	<input type="checkbox"/> Transfer to Disability Segment	
<input type="checkbox"/> Marriage or civil union (date: ____/____/____)	<input type="checkbox"/> Rehire (date: ____/____/____)	<input type="checkbox"/> Other	
<input type="checkbox"/> Birth (date: ____/____/____)	<input type="checkbox"/> Return from layoff (date: ____/____/____)		
<input type="checkbox"/> Adoption / Placement for Adoption (date: ____/____/____)			
<b>*By checking the box you are confirming your loss of other coverage entitles you to a Special Enrollment Period.</b>			
Primary Care Physician (PCP) or Nurse Practitioner (NP) and Clinic:			Current Patient <input type="checkbox"/> Yes <input type="checkbox"/> No
<small>Confirm your NP can be selected as a PCP at QuartzBenefits.com/findadoctor. If you have no PCP or NP preference, write "ASSIGN" and we will assign one for you.</small>			

## II. EMPLOYER INFORMATION

Name of Employer Group:	Date Employed: ____/____/____	Weekly Hours:	Requested Effective Date: ____/____/____
Employment Status: <input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> LOA	<input type="checkbox"/> COBRA / Continuation Effective Date ____/____/____		
<b>COBRA Reason:</b> <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	

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

Dependent's Last Name	First Name	MI
Social Security Number or Tax ID Number <small>(SSN / TIN is required for IRS tax reporting regarding your health plan.)</small> _____ - _____ - _____		
Does Dependent live at the same address as you? <input type="checkbox"/> Yes <input type="checkbox"/> No   If <b>No</b> list address:		
Mailing Address _____		
Apt. # _____ City _____ State _____ Zip Code _____ County _____		
Relationship to you	Date of Birth <small>(mm/dd/yyyy)</small> ____/____/____	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Primary Care Physician (PCP) and Clinic <small>Confirm your NP can be selected as a PCP at QuartzBenefits.com/findadoctor. If you have no PCP or NP preference, write "ASSIGN" and we will assign one for you.</small>		Current Patient <input type="checkbox"/> Yes <input type="checkbox"/> No

Dependent's Last Name	First Name	MI
Social Security Number or Tax ID Number <small>(SSN / TIN is required for IRS tax reporting regarding your health plan.)</small> _____ - _____ - _____		
Does Dependent live at the same address as you? <input type="checkbox"/> Yes <input type="checkbox"/> No   If <b>No</b> list address:		
Mailing Address _____		
Apt. # _____ City _____ State _____ Zip Code _____ County _____		
Relationship to you	Date of Birth <small>(mm/dd/yyyy)</small> ____/____/____	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Primary Care Physician (PCP) and Clinic <small>Confirm your NP can be selected as a PCP at QuartzBenefits.com/findadoctor. If you have no PCP or NP preference, write "ASSIGN" and we will assign one for you.</small>		Current Patient <input type="checkbox"/> Yes <input type="checkbox"/> No

Dependent's Last Name	First Name	MI
Social Security Number or Tax ID Number <small>(SSN / TIN is required for IRS tax reporting regarding your health plan.)</small> _____ - _____ - _____		
Does Dependent live at the same address as you? <input type="checkbox"/> Yes <input type="checkbox"/> No   If <b>No</b> list address:		
Mailing Address _____		
Apt. # _____ City _____ State _____ Zip Code _____ County _____		
Relationship to you	Date of Birth <small>(mm/dd/yyyy)</small> ____/____/____	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Primary Care Physician (PCP) and Clinic <small>Confirm your NP can be selected as a PCP at QuartzBenefits.com/findadoctor. If you have no PCP or NP preference, write "ASSIGN" and we will assign one for you.</small>		Current Patient <input type="checkbox"/> Yes <input type="checkbox"/> No

Dependent's Last Name	First Name	MI
Social Security Number or Tax ID Number <small>(SSN / TIN is required for IRS tax reporting regarding your health plan.)</small> _____ - _____ - _____		
Does Dependent live at the same address as you? <input type="checkbox"/> Yes <input type="checkbox"/> No   If <b>No</b> list address:		
Mailing Address _____		
Apt. # _____ City _____ State _____ Zip Code _____ County _____		
Relationship to you	Date of Birth <small>(mm/dd/yyyy)</small> ____/____/____	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Primary Care Physician (PCP) and Clinic <small>Confirm your NP can be selected as a PCP at QuartzBenefits.com/findadoctor. If you have no PCP or NP preference, write "ASSIGN" and we will assign one for you.</small>		Current Patient <input type="checkbox"/> Yes <input type="checkbox"/> No

**IV. OTHER INSURANCE INFORMATION:**

**Will you or any of your dependents continue to have other insurance after the Quartz effective date of this policy? If Yes, complete -**

Names of those covered under policy		Employer	
Insurance Company		Subscriber #	Group #
Effective Date of Coverage		Insurance Company Phone #	
Termination Date			
<b>Are you or your spouse or child(ren) covered by Medicare (Parts A, B, C, or D)?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list name(s):			
Reason for Medicare: <input type="checkbox"/> Age 65 <input type="checkbox"/> Disability <input type="checkbox"/> End Stage Renal Disease <input type="checkbox"/> Disability and ESRD			
Part A Effective Date: ___/___/_____		Part B Effective Date: ___/___/_____	
Part C Effective Date: ___/___/_____		Part D Effective Date: ___/___/_____	
<b>Are you or any dependents listed above involved in a Workers Compensation case?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, indicate who is 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.

**DENTAL DISCLAIMER**

This policy does not include pediatric dental services, which is an essential health benefit under the Affordable Care Act. This dental coverage is available in the insurance market as a stand-alone dental product. Please contact your insurance carrier, agent, Federally Facilitated Marketplace, or state-based Health Care Exchange if you wish to purchase pediatric dental coverage or a stand-alone dental product. By signing this application you are acknowledging this policy does not contain pediatric dental.

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 or 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 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 or civil union, 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 or civil union, birth, adoption or placement for adoption.