OMB No. 0938-1378
Expires: 12/31/2026

Individual enrollment request form to enroll in a Medicare Advantage Plan (Part C), Medicare Prescription Drug Plan (Part D), or Dual Eligible Special Needs Plans (D-SNP)

Who can use this form?

People with Medicare who want to join a Medicare Advantage Plan or Medicare Prescription Drug Plan.

To join a plan, you must:

- Be a United States citizen or be lawfully present in the U.S.
- Live in the plan's service area

Important: To join a Medicare Advantage Plan, you must also have both:

- Medicare Part A (Hospital Insurance)
- Medicare Part B (Medical Insurance)

When do I use this form?

You can join a plan:

- Between October 15 – December 7 each year (for coverage starting January 1)
- Within 3 months of first getting Medicare
- In certain situations where you're allowed to join or switch plans
- Visit **Medicare.gov** to learn more about when you can sign up for a plan

What do I need to complete this form?

- Your Medicare Number (the number on your red, white, and blue Medicare card)
- Your permanent address and phone number
- Note: You must complete all items in Section 1. The items in Section 2 are optional — you can't be denied coverage because you don't fill them out.

Reminders:

- If you want to join a plan during fall open enrollment (October 15 – December 7), the plan must get your completed form by December 7.

What happens next?

Send your completed and signed form to:
Quartz Medicare Advantage (HMO)
2650 Novation Parkway
Fitchburg, WI 53713

Once Quartz processes your request to join, we will contact you.

How do I get help with this form?

Call a Quartz Champion at **(800) 394-5566**. TTY users can call **711**. Or, call Medicare at **1-800-MEDICARE** (**1-800-633-4227**). TTY users can call **1-877-486-2048**.

En español: Llame a Quartz Medicare Advantage al **(800) 394-5566**/**TTY: 711** o a Medicare gratis al (**1-800-633-4227**) y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.

Individuals experiencing homelessness: If you want to join a plan, but have no permanent residence, a Post Office box, an address of a shelter or clinic, or the address where you receive mail (e.g., social security checks) may be considered your permanent residence address.

Effective Date: 01/01/2026
GH00569UW_C_0825 H5262_25 42a_C CMS ACCEPTED 09/02/2025

Quartz Medicare Advantage (HMO)
2650 Novation Parkway, Fitchburg, WI 53713
(800) 394-5566 or TTY: 711 • Fax (608) 881-8327
QuartzBenefits.com/MedicareAdvantage

2026 Enrollment application

Effective date: _____

SECTION 1 - all fields are required (unless marked optional)

Election type (please check one)

- ☐ Annual Election Period (AEP) from Oct. 15 – Dec. 7, 2025
- ☐ Open Enrollment Period from January 1 – March 31, 2026
- ☐ Initial Coverage Election Period (ICEP)
- ☐ Open Enrollment Period for Institutionalized Individuals (OEPI)
- ☐ Special Enrollment Period (complete SEP Attestation attached)

To enroll in Quartz Medicare Advantage (HMO), please provide the following information:

Your personal information

Last name:	First name:	MI (optional):

Date of birth: (MM/DD/YYYY)	Sex: ☐ Male ☐ Female	Home phone number:	Alternate phone number:

Permanent residence street address (Don't enter a PO Box). For individuals experiencing homelessness, a PO Box may be considered your permanent address.

Street address:

City:	State:	ZIP:	County (optional):

Mailing address, if different from your permanent address (PO Box allowed)

Address:

City:	State:	ZIP:

Please provide your Medicare insurance information

Please take out your red, white, and blue Medicare card to complete this section.

Fill out this information as it appears on your Medicare card.

-OR-

Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

Name (as it appears on your Medicare card):

Medicare number:

Is entitled to:

HOSPITAL (Part A)	MEDICAL (Part B)
Effective date:	Effective date:

You must have Medicare Parts A and B to join a Medicare Advantage plan.

I am applying for:

Quartz Medicare Advantage (HMO) with prescription coverage

- ☐ **Basic D** (with Rx) $0.00 monthly premium plan
- ☐ **Core D** (with Rx) $34.00 monthly premium plan
- ☐ **Value D** (with Rx) $106.00 monthly premium plan
- ☐ **Elite D** (with Rx) $162.00 monthly premium plan

Quartz Medicare Advantage (HMO) medical only

- ☐ **Value** (no Rx) $0.00 monthly premium plan
- ☐ **Elite** (no Rx) $70.00 monthly premium plan

UW Health Quartz Medicare Advantage Dual Eligible with Rx
Available in Dane County only.

- ☐ $0 monthly premium plan

Optional supplemental dental benefit*

☐ Yes, I would like to buy the supplemental dental benefit option for an additional $59.00 monthly for Basic D and Core D, or $48.00 monthly for Value, Value D, Elite, and Elite D.

*Not available for the UW Health Quartz Medicare Advantage Dual Eligible with Rx plan.

Please answer the following questions to help Medicare coordinate your benefits

Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal Employee Health Benefits coverage, VA Benefits, Senior Care, or State pharmaceutical assistance programs.

Will you have other prescription drug coverage in addition to Quartz Medicare Advantage?

☐ Yes ☐ No

- If yes, name of the other drug coverage: _____
- ID # for drug coverage: _____
- Group # for drug coverage: _____

SECTION 2 – all fields in this section are optional. Answering these questions is your choice. You cannot be denied coverage because you don't fill them out.

Who is your primary care provider and what clinic do you go to for care?

Primary care provider (please specify):

Clinic name (please specify):

I prefer to receive the following materials electronically via email (if possible). Select one or more:

- ☐ Explanation of Benefits (EOBs)
- ☐ Coverage/Organization Determination, Discharge, Appeals and Grievances Notices
- ☐ Opt out of receiving email communication

Email address: _____

Text message communications preference (check one)

☐ Opt in to receiving text messages
☐ Opt out of receiving text messages

Mobile phone number: _____
Text messaging will be limited to outreach. Message and data rates may apply.

Select one if you want us to send your information in an accessible format.

☐ Large print
☐ Audio CD
☐ Data CD

Please contact a Quartz Champion at **(800) 394-5566 (TTY: 711)** if you need information in an accessible format other than what's listed here. Our office hours are:
April 1 – Sept. 30, Mon. – Friday, 8 a.m. – 8 p.m., Oct. 1 – March 31, seven days a week, 8 a.m. – 8 p.m.

Preferred language? (Spoken and written. Please check one.)

☐ English
☐ Spanish
☐ American Sign Language
☐ Chinese
☐ German
☐ Hmong
☐ Other (please specify): _____

Please answer the following questions to help Medicare coordinate your benefits

1. Are you enrolled in your State Medicaid program?
☐ Yes ☐ No
- If yes, please provide your Medicaid number: _____
- To be completed by agent. Medicaid verified? ☐ Yes ☐ No Who verified? _____

2. Do you, on your own or through your spouse, have any medical or health insurance other than Medicare, such as private insurance or Workers' Compensation?
☐ Yes ☐ No
- If yes, what is the name of your insurance? _____
- Type of insurance: ☐ Group ☐ Individual ☐ Medicare Supplement ☐ Other: _____
- Effective date of coverage: _____
- Will you be keeping this health insurance in addition to Quartz Medicare Advantage? ☐ Yes ☐ No
- **If no,** please provide the end date of the other coverage: _____

SECTION 3 - all fields are required (unless marked optional)

Understanding your plan

By initialing to the right, you are certifying that you have read and understood all of the statements below. You must agree to all of these terms to enroll in Quartz Medicare Advantage.

Initial here: _____

1. I must keep Hospital (Part A) and Medical (Part B) to stay enrolled in Quartz Medicare Advantage.
2. I understand that people with Medicare aren't usually covered under Medicare while out of the country; however, as a Quartz Medicare Advantage member, I'm covered anywhere in the world for urgent and emergency services.
3. I understand that when my Quartz Medicare Advantage coverage begins, I must get all of my medical and prescription drug benefits from Quartz Medicare Advantage. Benefits and services provided by Quartz Medicare Advantage and contained in my Quartz Medicare Advantage "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Quartz Medicare Advantage will pay for benefits or services that are not covered.
4. I understand that I can be enrolled in only one Medicare Advantage or Part D plan at a time - and that enrollment in this plan will automatically end my enrollment in another MA or Part D plan (exceptions apply for MA PFFS, MA MSA plans).
5. By joining this Quartz Medicare Advantage plan or Medicare Prescription Drug plan, I acknowledge that Quartz Medicare Advantage will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by federal law that authorize the collection of this information (see Privacy Act Statement on page 7). Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
6. I understand that if I don't have Medicare prescription drug coverage or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty in addition to my premium for Medicare prescription drug coverage in the future.
7. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.
8. I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I've read and understood the application's content. If signed by an authorized representative (as described above), this signature certifies that: 1) this person is authorized under state law to complete this enrollment; and 2) documentation of this authority is available upon request by Medicare.

Paying your plan premium (not applicable to Dual Eligible plans)

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail, with an automatic checking or savings account deduction. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month. If you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you must pay this extra amount in addition to your plan premium. Do not pay Quartz Medicare Advantage the Part D-IRMAA.

Please select a premium payment option (not applicable to Dual Eligible plans)

☐ **Automatic deduction – checking or savings account**
(complete the automatic payment authorization form)

- By selecting this option, I authorize Quartz Medicare Advantage (HMO) to initiate electronic fund transfers drawn on my bank account, on the fourth business day of the month, for the payment of my plan premium. I further authorize the bank to debit my bank account on or about the fourth business day of the month.
- I realize that my bank shall be under no obligation to furnish me with any special advice or notice of the payment of any such transaction, other than my monthly bank statement. I realize the electronic funds transfers will begin approximately 30 days after submitting this request. The effective date will be the date shown on the written confirmation I will receive from Quartz Medicare Advantage.
- I understand that if for any reason funds are not available for withdrawal in the account listed on this form, Quartz Medicare Advantage reserves the right to change my billing method to direct billing by sending me an invoice and requiring that my payments be made by check or money order.

☐ **Automatic deduction – monthly Social Security benefit check**

☐ **Automatic deduction – monthly Railroad Retirement Board benefit check**

- The Social Security/Railroad Retirement Board deduction may take two or more months to begin.
- We will send you a confirmation letter with the effective date of this deduction. You are responsible for payment before the effective date of this automatic deduction.
- If Social Security/Railroad Retirement Board does not approve your request for automatic deduction, we will send you an invoice for your monthly premiums.

☐ **I will make my own payments – monthly or recurring payments**

- Select this option if you choose to pay with:
  - Invoice - use your invoice to mail in money order or check
  - Quartz MyChart - make a one-time payment or set up recurring payments using a checking or savings account and/or credit card. Sign up at **QuartzMyChart.com/Quartz/SignUp**.
  - Automated phone system - call **(800) 394-5566 (TTY: 711)** 24/7 to pay with Electronic Funds Transfer, credit, or debit card. Have your account number ready (begins with a 7, 8, or 9).

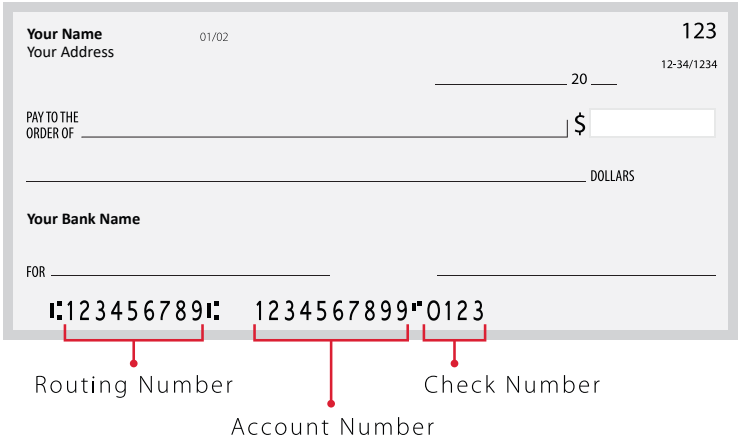
Complete this automatic payment authorization form if electing automatic deduction from bank account (not applicable to Dual Eligible plans)

Your bank name:

Routing number:

Account number:

☐ Checking ☐ Savings



Read this important information

If you are a member of a Medicare Advantage Plan (like an HMO or PPO), you may already have prescription drug coverage from your Medicare Advantage plan that will meet your needs. By joining Quartz Medicare Advantage, your membership in your current Medicare Advantage plan may end. This will affect both your doctor and hospital coverage as well as your prescription drug coverage. Read the information that your Medicare Advantage plan sends you and if you have questions, contact your Medicare Advantage plan.

If you currently have health coverage from an employer or union, joining Quartz Medicare Advantage could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Quartz Medicare Advantage. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there isn't any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Release of information

By joining this Medicare health or prescription drug plan, I acknowledge that Quartz Medicare Advantage will release my information to Medicare and other plans as is necessary for treatment, payment, and health care operations. I also acknowledge that Quartz Medicare Advantage will release my information including my prescription drug event data to Medicare, who may release it for research and other purposes, which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the state where I live) on this application means that I have read and understood the contents of this application. If signed by an authorized individual (as described above) this signature certifies that 1) this person is authorized under state law to complete this enrollment; and 2) documentation of this authority is available upon request from Quartz Medicare Advantage or Medicare.

Signature: _____ Today's date: _____

If you are the authorized representative, you must sign the release of information above and provide the following information

Last name:	First name:	MI:

Address:

Relationship to enrollee:	Phone number:

For individuals helping enrollee with completing this form only
Complete this section if you're an individual (i.e. agents, brokers, SHIP counselors, family members, or other third parties) helping an enrollee fill out this form.

Name of staff member/agent/broker (if assisted in enrollment):

Relationship to enrollee:

Signature:

National Producer Number (Agents/Brokers only):

Additional comments:

Agent use only

☐ I understand that I must complete and retain a Scope of Appointment for all sales for the required period of 10 years. I do not need to submit a copy of the Scope of Appointment to Quartz, but Quartz may request a copy of any Scope of Appointment associated with an application, at any time. I understand that I am required to respond timely and cooperate with any requests and disciplinary action, including non-compensation, will be taken if I cannot produce a valid Scope of Appointment.

Submit this application to:
Quartz Medicare Advantage
2650 Novation Parkway
Fitchburg, WI 53713

Or by email at: **MedicareAdvantage@QuartzBenefits.com**

Call a Quartz Champion at **(800) 394-5566**.
For people who are deaf, hard of hearing or speech impaired, call **TTY 711**.
Monday - Friday, 8 a.m. - 8 p.m., October 1 - March 31, seven days a week from 8 a.m. - 8 p.m.

PRIVACY ACT STATEMENT The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) or Prescription Drug Plans (PDP), improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50, 422.60, 423.30 and 423.32 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

Complete only if enrolling using a SEP election.

Attestation of eligibility for an enrollment period

Typically, you may enroll in a Medicare Advantage plan only during the Annual Enrollment Period (AEP) from Oct. 15 - Dec. 7 of each year. However, some exceptions may allow you to enroll in a Medicare Advantage plan outside of the AEP. Please read the following statements carefully, and check the box next to the one that applies to you. By checking any of the following boxes, you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

☐ I am new to Medicare.

☐ I am enrolled in a Medicare Advantage Plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).

☐ I recently moved outside of the service area for my current plan or I recently moved, and this plan is a new option for me. I moved on (insert date) _____.

☐ I recently was released from incarceration. I was released on (insert date) _____.

☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) _____.

☐ I recently obtained lawful presence status in the United States. I got this status on (insert date) _____.

☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date) _____.

☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (insert date) _____.

☐ I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra help paying for my Medicare prescription drug coverage, but I haven't had a change.

☐ I am moving into, live in, or recently moved out of a long-term care facility (for example, a nursing home or long-term care facility). I moved/will move into/out of the facility on (insert date) _____.

☐ I recently left a PACE program on (insert date) _____.

☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date) _____.

☐ I am leaving my employer's or union's coverage on (insert date) _____.

Attestation of eligibility for an enrollment period

☐ I belong to a pharmacy assistance program provided by my state.

☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.

☐ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date) _____.

☐ I was enrolled in a Special Needs Plan (SNP) but I lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date) _____.

☐ I was affected by an emergency or a major disaster (as declared by the Federal Emergency Management Agency, or by Federal, my state or my local government). One of the other statements on this page applied to me, but I was unable to make my request because of the disaster.

☐ I recently received a notice of retroactive Medicare entitlement determination. I received the notice on (insert date) _____.

If none of these statements apply to you or you're not sure you're eligible to enroll, please call a Quartz Champion at (800) 394-5566 (TTY: 711).