

# 2024 Individual insurance election form — Quartz Performance Network



2650 Novation Parkway • Fitchburg, WI 53713-3399  
(800) 926-8227 • Fax (608) 471-4394  
QuartzBenefits.com

In order to enroll in Quartz individual insurance coverage, you will need to complete the applicant information and the individual insurance election form

Requested coverage effective date \_\_\_\_/\_\_\_\_/2024

## 1. Plan options: (Please select a plan type.)

Network: Quartz Performance

Plan type					
Plan name	Platinum	Gold	Silver	Bronze	Catastrophic
	<input type="checkbox"/> Platinum I501	<input type="checkbox"/> Gold I401 <input type="checkbox"/> Gold I402 Maintenance <input type="checkbox"/> Gold I403 HSA* <input type="checkbox"/> Gold I410 Standard <input type="checkbox"/> Gold I420	<input type="checkbox"/> Silver I303 <input type="checkbox"/> Silver I304 HSA* <input type="checkbox"/> Silver I308 <input type="checkbox"/> Silver I309 Standard <input type="checkbox"/> Silver I320	<input type="checkbox"/> Bronze I201 <input type="checkbox"/> Bronze I203 HSA* <input type="checkbox"/> Bronze I204 <input type="checkbox"/> Bronze I205 <input type="checkbox"/> Bronze I206 Standard	<input type="checkbox"/> Catastrophic I101  <i>Only individuals under 30 years old or with a hardship exemption qualify for Catastrophic Plans.</i>

Is this a child-only policy? ☐ Yes ☐ No

If yes, are you the legal guardian or custodial parent? ☐ Yes ☐ No

### Pediatric dental services

*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.*

☐ 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.

### Dental option

☐ Yes - I'd like to elect dental coverage for all members of my policy.

☐ No - I do not want dental coverage for any members of my policy.

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

\*The combined family dental option is not available.

## 2. Primary care 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 clinic name and city	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

Continue to the next page. →

### 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: \_\_\_\_\_

☐ Birth/Adoption/Foster care

☐ Marital status change

☐ 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): \_\_\_\_\_

☐ The coverage I am applying for on this application is intended to replace the coverage listed above.

### 5. Invoice and payment options

Applicants will receive a paper invoice in the mail. Acceptable forms of payment include paper checks, cashier's checks, money orders, credit cards, and all general-purpose pre-paid debit cards. You can also arrange one-time or recurring Automated Clearing House (ACH) payments by contacting our Customer Success team at (800) 362-3310.

Applicant's full name (please print): \_\_\_\_\_ Date: \_\_\_\_\_

Applicant's signature: \_\_\_\_\_

Continue to the next page. →

# Applicant information

**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. Cell phone number:

15. Other phone number:

16. Email address:

17. Do you need health coverage?

☐ Yes

☐ No

18. Social Security Number (SSN) or Taxpayer Identification Number (TIN):

\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_

19. Sex:

☐ Male

☐ Female

20. Date of birth (mm/dd/yyyy):

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

21. Do you use tobacco (required if age 21+)?

☐ Yes

☐ No

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

22. Language (preferred spoken and written).  
Please check one:

☐ English

☐ Chinese

☐ Spanish

☐ American Sign Language

☐ Hmong

☐ Other (please specify)

☐ German

\_\_\_\_\_

23. Race (defined as a person's identification with one or more social groups).  
Please select all that apply:

☐ American Indian or Alaska Native

☐ White

☐ Asian

☐ Declines to answer

☐ Black or African American

☐ Unavailable

☐ Native Hawaiian or other Pacific Islander

24. Ethnicity (refers to shared cultural characteristics such as language, ancestry, practices, and beliefs. For this application, ethnicity is broken out into two categories: Hispanic or Latino and Not Hispanic or Latino). Please check one:

☐ Hispanic or Latino

☐ Not Hispanic or Latino

☐ Declines to answer

☐ Unavailable

Continue to the next page. →

# Applicant information

## 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 (SSN) or Taxpayer Identification Number (TIN):

\_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

4. Sex:

☐ Male

☐ Female

5. Date of birth (mm/dd/yyyy):

\_\_\_\_/\_\_\_\_/\_\_\_\_

6. Cell phone number:

7. Email address:

8. Does person 2 live at the same address as you? ☐ Yes ☐ No If no, list address:

9. Does person 2 use tobacco (required if age 21+)? ☐ Yes ☐ No

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

10. Language for person 2 (preferred spoken and written). Please check one:

☐ English

☐ Chinese

☐ Spanish

☐ American Sign Language

☐ Hmong

☐ Other (please specify)

☐ German

\_\_\_\_\_

11. Race for person 2 (defined as a person's identification with one or more social groups). Please select all that apply:

☐ American Indian or Alaska Native

☐ White

☐ Asian

☐ Declines to answer

☐ Black or African American

☐ Unavailable

☐ Native Hawaiian or other Pacific Islander

12. Ethnicity for person 2 (refers to shared cultural characteristics such as language, ancestry, practices, and beliefs. For this application, ethnicity is broken out into two categories: Hispanic or Latino and Not Hispanic or Latino). Please check one:

☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declines to answer ☐ Unavailable

### Step 2: Person 3

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

2. Relationship to you:

3. Social Security Number (SSN) or Taxpayer Identification Number (TIN):

\_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

4. Sex:

☐ Male

☐ Female

5. Date of birth (mm/dd/yyyy):

\_\_\_\_/\_\_\_\_/\_\_\_\_

6. Cell phone number:

7. Email address:

8. Does person 3 live at the same address as you? ☐ Yes ☐ No If no, list address:

9. Does person 3 use tobacco (required if age 21+)? ☐ Yes ☐ No

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

Continue to the next page. →

10. Language for person 3 (preferred spoken and written). Please check one:

- ☐ English      ☐ Chinese  
☐ Spanish      ☐ American Sign Language  
☐ Hmong      ☐ Other (please specify) \_\_\_\_\_  
☐ German

11. Race for person 3 (defined as a person's identification with one or more social groups). Please select all that apply:

- ☐ American Indian or Alaska Native      ☐ White  
☐ Asian      ☐ Declines to answer  
☐ Black or African American      ☐ Unavailable  
☐ Native Hawaiian or other Pacific Islander

12. Ethnicity for person 3 (refers to shared cultural characteristics such as language, ancestry, practices, and beliefs. For this application, ethnicity is broken out into two categories: Hispanic or Latino and Not Hispanic or Latino). Please check one:

- ☐ Hispanic or Latino    ☐ Not Hispanic or Latino    ☐ Declines to answer    ☐ Unavailable

## Step 2: Person 4

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

2. Relationship to you:

3. Social Security Number (SSN) or Taxpayer Identification Number (TIN):

\_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

4. Sex:

- ☐ Male    ☐ Female

5. Date of birth (mm/dd/yyyy):

\_\_\_\_/\_\_\_\_/\_\_\_\_

6. Cell phone number:

7. Email address:

8. Does person 4 live at the same address as you?    ☐ Yes    ☐ No    If no, list address:

9. Does person 4 use tobacco (required if age 21+)?    ☐ Yes    ☐ No

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

10. Language for person 4 (preferred spoken and written). Please check one

- ☐ English      ☐ Chinese  
☐ Spanish      ☐ American Sign Language  
☐ Hmong      ☐ Other (please specify) \_\_\_\_\_  
☐ German

11. Race for person 4 (defined as a person's identification with one or more social groups). Please select all that apply:

- ☐ American Indian or Alaska Native      ☐ White  
☐ Asian      ☐ Declines to answer  
☐ Black or African American      ☐ Unavailable  
☐ Native Hawaiian or other Pacific Islander

12. Ethnicity for Person 4 (refers to shared cultural characteristics such as language, ancestry, practices, and beliefs. For this application, ethnicity is broken out into two categories: Hispanic or Latino and Not Hispanic or Latino). Please check one:

- ☐ Hispanic or Latino    ☐ Not Hispanic or Latino    ☐ Declines to answer    ☐ Unavailable

Continue to the next page. →

# Applicant information

## 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 in step 6 of this application. 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 of a material fact relied upon by the insurer may be used to deny a claim. I further understand that this contract can be voided if 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.

Signature: \_\_\_\_\_ Date signed: \_\_\_\_\_

## Step 4: Mail or email your completed application.

Mail your completed application to:

**Quartz – Sales Department**  
**2650 Novation Parkway**  
**Fitchburg, WI 53713**

Scan and email your completed application to:

**IndividualSales@QuartzBenefits.com**

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# Applicant information

**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.

Continue to the next page. →

# Applicant information

## 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 someone else.

1. Application start date (mm/dd/yyyy):

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

3. Organization name:

4. ID number (if applicable):

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.