Employee Application
Illinois Groups

Please Complete Entire Form in BLACK INK

☐ HMO offered by Quartz Health Benefit Plans Corporation
☐ POS jointly offered by Quartz Health Benefit Plans Corporation and Quartz Health Insurance Corporation
☐ PPO offered by Quartz Health Insurance Corporation

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

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

☐ New ☐ Change	Employee's Last Name	First Name	MI

Social Security Number or Tax ID Number
(SSN / TIN is required for IRS tax reporting regarding your health plan.) _____ _____ _____ — _____ _____ — _____ _____ _____ _____

Street Address	Apt. #	City	State	Zip Code	County
Mailing Address *(if different)*		**City**	**State**	**Zip Code**	**County**

Date of Birth *(mm/dd/yyyy)* ____/____/_____

Sex ☐ Male ☐ Female

Marital Status ☐ Single ☐ Divorced ☐ Married, Civil Union, Domestic Partnership (date: ____/____/_____)

Language. Preferred spoken and written. Please check one:
- ☐ English
- ☐ Spanish
- ☐ Hmong
- ☐ German
- ☐ Chinese
- ☐ American Sign Language
- ☐ Other (please specify)_____

Race. Defined as a person's identification with one or more social groups. Please select all that apply:
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Pacific Islander
- ☐ White
- ☐ Declines to answer
- ☐ Unavailable

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

Primary Phone # ( )

Email Address:

Primary Care Clinic Name: _____
Primary Care Clinic City: _____

Plan Requested: ☐ HMO _____ Group Number: _____ ☐ POS _____ Group Number: _____ ☐ PPO _____ Group Number: _____

Type of Coverage: ☐ Employee ☐ Employee and Spouse or partner in civil union ☐ Employee and Child(ren) ☐ Family
☐ **WAIVING COVERAGE (skip to section V. Waiver of Group Coverage)**
If married and only selecting coverage for yourself, please complete section V. for your spouse/partner in civil union/children.

Reason for Enrollment: (check appropriate box)
- ☐ New Hire
- ☐ Loss of Other Coverage*
- ☐ Open Enrollment
- ☐ Marriage, Civil Union, Domestic Partnership (date: ____/____/_____)
- ☐ Birth (date: ____/____/_____)
- ☐ Adoption / Placement for Adoption (date: ____/____/_____)
- ☐ Add / Delete Dependents
- ☐ Part-Time to Full-Time Employment (date of change: ____/____/_____)
- ☐ COBRA / State Continuation
- ☐ Rehire (date: ____/____/_____)
- ☐ Return from layoff (date: ____/____/_____)
- ☐ Name Change / Address Change / PCP or NP Change
- ☐ Transfer to Retiree Segment
- ☐ Transfer to Disability Segment
- ☐ Other

By checking the box you are confirming your loss of other coverage entitles you to a Special Enrollment Period.

II. EMPLOYER INFORMATION

Name of Employer Group:	Date Employed:	Weekly Hours:	Requested Effective Date:
	____/____/_____		____/____/_____

Employment Status: ☐ Active ☐ Retired ☐ LOA ☐ COBRA / Continuation Effective Date ____/____/_____

COBRA Reason: ☐ End of Employment ☐ Death of Employee ☐ Entitlement to Medicare ☐ Reduction in Hours of Employment ☐ Divorce or Legal Separation ☐ 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
(SSN / TIN is required for IRS tax reporting regarding your health plan.) ___ ___ ___ — ___ ___ — ___ ___ ___ ___

Does Dependent live at the same address as you? ☐ Yes ☐ No If **No** list address:

Mailing Address _____

Apt. # _____ City _____ State _____ Zip Code _____ County _____

Relationship to you | Date of Birth *(mm/dd/yyyy)* ____/____/_____ | Sex ☐ Male ☐ Female

Language. Preferred spoken and written. Please check one:
- ☐ English
- ☐ Spanish
- ☐ Hmong
- ☐ German
- ☐ Chinese
- ☐ American Sign Language
- ☐ Other (please specify) _____

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

Primary Care Clinic Name: | Primary Care Clinic City:

Dependent's Last Name | First Name | MI

Social Security Number or Tax ID Number
(SSN / TIN is required for IRS tax reporting regarding your health plan.) ___ ___ ___ — ___ ___ — ___ ___ ___ ___

Does Dependent live at the same address as you? ☐ Yes ☐ No If **No** list address:

Mailing Address _____

Apt. # _____ City _____ State _____ Zip Code _____ County _____

Relationship to you | Date of Birth *(mm/dd/yyyy)* ____/____/_____ | Sex ☐ Male ☐ Female

Language. Preferred spoken and written. Please check one:
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- ☐ Unavailable

Primary Care Clinic Name: | Primary Care Clinic City:

Dependent's Last Name	First Name	MI

Social Security Number or Tax ID Number
(SSN / TIN is required for IRS tax reporting regarding your health plan.) ____ ____ ____ — ____ ____ — ____ ____ ____ ____

Does Dependent live at the same address as you? ☐ Yes ☐ No If **No** list address:

Mailing Address _____

Apt. # _____ City _____ State _____ Zip Code _____ County _____

Relationship to you	Date of Birth *(mm/dd/yyyy)* ____/____/_____	Sex ☐ Male ☐ Female

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Primary Care Clinic Name:	Primary Care Clinic City:

Dependent's Last Name	First Name	MI

Social Security Number or Tax ID Number
(SSN / TIN is required for IRS tax reporting regarding your health plan.) ____ ____ ____ — ____ ____ — ____ ____ ____ ____

Does Dependent live at the same address as you? ☐ Yes ☐ No If **No** list address:

Mailing Address _____

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Relationship to you	Date of Birth *(mm/dd/yyyy)* ____/____/_____	Sex ☐ Male ☐ Female

Language. Preferred spoken and written. Please check one:	Race. Defined as a person's identification with one or more social groups. Please select all that apply:	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:
☐ English ☐ Spanish ☐ Hmong ☐ German ☐ Chinese ☐ American Sign Language ☐ Other (please specify) _____	☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ White ☐ Declines to answer ☐ Unavailable	☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declines to answer ☐ Unavailable

Primary Care Clinic Name:	Primary Care Clinic City:

IV. OTHER INSURANCE INFORMATION:		
1. Are you or your spouse, partner in civil union, or child(ren) covered by Medicare (Parts A, B, C, or D)? ☐ Yes ☐ No If yes, please list name(s):		
Reason for Medicare: ☐ Age 65 ☐ Disability ☐ End Stage Renal Disease ☐ Disability and ESRD		
Part A Effective Date: ____/____/_____ Part B Effective Date:____/____/_____ Part C Effective Date: ____/____/_____ Part D Effective Date:____/____/_____		Medicare Beneficiary Identified (MBI):
2. Are you or any dependents listed above involved in a Workers Compensation case? ☐ Yes ☐ No If Yes, indicate who is involved and start date / accident date:		
3. 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		

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.: _____

☐ 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 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_____

If you are **electing coverage for yourself**, please make sure you sign page 3 of the application.

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse or partner in civil union) 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.