Illinois Employer Group Application

☐ New Group

☐ Renewing Group / Change*

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(800) 362-3310 • Fax (608) 643-2564
QuartzBenefits.com

☐ 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

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 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%

**** 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.**

Section A – General Employer Information

1.	Exact Legal Name of Employer Group (Policyholder):
	Federal Tax ID: Name of d / b / a (doing business as):
2.	Mailing Address: City: State: Zip Code:
3.	County of primary location within the Quartz service area: Phone Number: ( )
4.	Control Group, if any:
	Control Group Federal Tax ID: Number of employees at Control Group including all subsidiaries:
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(s):
	Do you want coverage for any subsidiaries? ☐ Yes ☐ No
	a. If Yes, give legal name, Tax ID, and address of each:
	b. If No, give legal name, Tax ID, and address of each affiliate not included and identify number of employees and insurance carrier for each:
6.	Is your company a municipality? ☐ Yes ☐ No
7.	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.*

ONLY FOR GROUPS WITH MORE THAN 50 TOTAL EMPLOYEES

8.	Is this coverage part of a union negotiated agreement? ☐ Yes ☐ No If Yes, Next Union Contract Review Date: _____ *(Month / Day / Year)*
9.	Nature of Business:
10.	How long has your company been in business?

Section B – Plan Selection

1.	BENEFIT PLAN: ☐ 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
2.	For Groups under 50 employees: Quartz Small Group Benefit Plan Name(s): _____ Please write in the plan name exactly how it appears on the rate sheet.

Section C – Plan Information

1.	Requested effective date: (COVERAGE IS NOT EFFECTIVE UNTIL WE NOTIFY YOU IN WRITING)
2.	Hourly Requirement: ☐ 30 hours (Default) ☐ 20 hours
3.	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:
4.	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.
5.	If your company is exempt from state workers' compensation requirements, check here: ☐
6.	Percent of medical insurance premium paid by Employer: Single:_____% (Minimum Requirement for Small Groups is 50%) Family:_____%
7.	Are you requesting a Health Reimbursement Account? ☐ Yes ☐ No If yes, name of vendor:
8.	Probationary Period for new employees (May not exceed 90 calendar days) First of the month following: ☐ 0 days ☐ 30 days ☐ 60 days **OR** Immediately following: ☐ 0 days ☐ 30 days ☐ 60 days ☐ 90 days
9.	Is the probationary period the same as listed in question 8 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 within 12 months: ☐ Yes ☐ No **If no, please explain eligibility guidelines:**
	Return from layoff within 12 months: ☐ Yes ☐ No **If no, please explain eligibility guidelines:**
	Rehire within 6 months: ☐ Yes ☐ No **If no, please explain eligibility guidelines:**
	Would you like the probationary period waived for initial enrollment? ☐ Yes ☐ No

ONLY FOR GROUPS WITH MORE THAN 50 TOTAL EMPLOYEES

10.	Are you applying for replacement of your current group medical coverage? ☐ Yes ☐ No If Yes, you must furnish the following information:
	Name of current group carrier: Original effective date: **Attach your most recent billing statement.**
11.	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.**
12.	Do you have variable hour employees? ☐ Yes ☐ No If yes, please explain eligibility guidelines:
13.	Are you requesting domestic partner coverage? ☐ Yes ☐ No

Section D – 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.

Section E – 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: ( )

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: _____

Section F – 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:_____ Name: _____
(Month / Day / Year) (Print Employer Name)

Signature: _____
(Employer Signature)

Title: _____

Section G – 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. 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.

2. Enter the average number of full, part-time, and seasonal employees employed during the preceding calendar year (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.*

3. Medicare Secondary Payer provisions apply to employers that have 20 or more full-time and / or part-time employees for each working day in each of 20 or more calendar weeks in the current or preceding year. When calculating your number of full-time and part-time employees you must use the total number of employees in your organizational structure including the parent company, subsidiaries, etc.
   ☐ 2 – 19 employees ☐ 20 or more employees

4. Medicare Secondary Payer disability provisions have a different rule for reporting group size for disabled employees. When calculating your number of full-time and part-time employees you must use the total number of employees in your organizational structure including the parent company, subsidiaries, etc. Did you employ 100 or more full-time and part-time employees on 50% or more of your regular business days during the previous calendar year?
   ☐ Yes ☐ No
   The Medicare Secondary Payer regulations as dictated by CMS require you to report any changes in employment during the course of the year that could impact your employer size determination related to the 20 employees or more requirements described above. In other words, you must notify us when you have had an increase to a size of 20 or more full-time and part-time employees for 20 or more weeks during the current calendar year.

5. COBRA applies to employers that employ 20 or more full-time and part-time employees on 50% of the business days during the preceding calendar year. Part-time employees count as a fraction of a full-time employee and should be counted in this manner.
   ☐ 2-19 employees
   ☐ 20 or more employees

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)

Quartz