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

2650 Novation Parkway • Fitchburg, WI 53713-3399
(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 (list group number) _____ ☐ POS (list group number) _____ ☐ PPO (list 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: ___/___/_____)
- ☐ 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

Primary care clinic name: | Primary care clinic city:

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

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- ☐ Native Hawaiian or Pacific Islander
- ☐ White
- ☐ Declines to answer
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- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Declines to answer
- ☐ Unavailable

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

Primary care clinic name: | Primary care clinic city:

Language (preferred spoken and written). Please check one:
- ☐ English
- ☐ Spanish
- ☐ Hmong
- ☐ German
- ☐ Chinese
- ☐ American Sign Language
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- ☐ Unavailable

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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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

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

Primary care clinic name:	Primary care clinic city:

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

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
Primary care clinic name:	Primary care clinic city:	

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

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
Primary care clinic name:	Primary care clinic city:	

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

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 identifier (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 and insurance company name:

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_____

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, or within 60 days of the birth, adoption, or placement for adoption.

Quartz®

Non-Discrimination & Language Access

Quartz is the brand name for a group of companies committed to your health: Quartz Health Benefit Plans Corporation, Quartz Health Insurance Corporation, Quartz Health Plan Corporation, and Quartz Health Plan MN Corporation. These companies are separate legal entities. In this notice, "we" refers to all Quartz companies.

For assistance understanding these materials in a language other than English, call (800) 362-3310, and a Customer Success representative will assist you. TTY users should call 711 or (800) 877-8973.

We comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex, including sexual orientation and gender identity.

We provide free aids and services to people with disabilities to communicate effectively with us, such as –

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

We provide free language services to people whose primary language is not English, such as –

- Qualified interpreter
- Information written in other languages

If you need these services, contact Customer Success at (800) 362-3310.

If you believe we failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, including sexual orientation and gender identity, you can file a grievance with –

Kristie Breunig, Compliance Officer
2650 Novation Parkway
Madison, WI 53713
Phone: (800) 362-3310
TTY: 711 or toll-free (800) 877-8973
Fax: (608) 644-3500
Email: AppealsSpecialists@QuartzBenefits.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Kristie Breunig, Compliance Officer, is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
(800) 368-1019; (800) 537-7697 (TDD)

Complaint forms are available at hhs.gov/ocr/office/file/index.html

Quartz is a Qualified Health Plan issuer in the Health Insurance Marketplace in certain states. To learn more, visit the Health Insurance Marketplace at HealthCare.gov.

For help to translate or understand this, please call (800) 362-3310, TTY: 711 / (800) 877-8973.

Spanish – Este Aviso contiene información importante. Este aviso contiene información importante acerca de su solicitud o cobertura a través de Quartz. Preste atención a las fechas clave que contiene este aviso. Es posible que deba tomar alguna medida antes de determinadas fechas para mantener su cobertura médica o ayuda con los costos. Usted tiene derecho a recibir esta información y ayuda en su idioma sin costo alguno. Llame al (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

Hmong – Tsab ntawv tshaj xo no muaj cov ntshiab lus tseem ceeb. Tsab ntawv tshaj xo no muaj cov ntsiab lus tseem ceeb txog koj daim ntawv thov kev pab los yog koj qhov kev pab cuam los ntawm Quartz. Saib cov caij nyoog los yog tej hnub tseem ceeb uas sau rau hauv daim ntawv no kom zoo. Tej zaum koj kuj yuav tau ua qee yam uas peb kom koj ua tsis pub dhau cov caij nyoog uas teev tseg rau hauv daim ntawv no mas koj thiaj yuav tau txais kev pab cuam kho mob los yog kev pab them tej nqi kho mob ntawd. Koj muaj cai kom lawv muab cov ntshiab lus no uas tau muab sau ua koj hom lus pub dawb rau koj. Hu rau (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

Vietnamese – Thông báo này cung cấp thông tin quan trọng. Thông báo này có thông tin quan trọng bàn về đơn nộp hoặc hợp đồng bảo hiểm qua chương trình Quartz. Xin xem ngày then chốt trong thông báo này. Quý vị có thể phải thực hiện theo thông báo đúng trong thời hạn để duy trì bảo hiểm sức khỏe hoặc được trợ trúp thêm về chi phí. Quý vị có quyền được biết thông tin này và được trợ giúp bằng ngôn ngữ của mình miễn phí. Xin gọi số (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

Chinese – 本通知含有重要的訊息 本通知對於您透過 Quartz 所提 出的申請或保險有重要的訊息 請在本通知中查看重要的日期 您可能要在特定的截止日期之 前採取行動，以保留您的健康保險或有助於省錢 您有權利免費以您的母語得到幫助和訊息 請致電 (800) 362-3310：711 / (800) 877-8973.

Russian – Настоящее уведомление содержит важную информацию. Это уведомление содержит важную информацию о вашем заявлении или страховом покрытии через Quartz. Посмотрите на ключевые даты в настоящем уведомлении. Вам, возможно, потребуется принять меры к определенным предельным срокам для сохранения страхового покрытия или помощи с расходами. Вы имеете право на бесплатное получение этой информации и помощь на вашем языке. Звоните по телефону (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

Laotian – ແຈ້ງການສະບັບນີ້ມີຂໍ້ມູນທີ່ສຳຄັນ.
ແຈ້ງການສະບັບນີ້ມີຂໍ້ມູນທີ່ສຳຄັນກ່ຽວກັບໃບສະໝັກ ຫຼື ການຄຸ້ມຄອງຂອງທ່ານຜ່ານ Quartz. ຊອກຫາວັນທີສຳຄັນ ໃນຫນັງສືແຈ້ງການສະບັບນີ້.ທ່ານອາດຈຳເປັນຕ້ອງປະຕິບັດຕາມເວລາ ທີ່ກຳນົດໄວ້ທີ່ແນ່ນອນເພື່ອຮັກສາໄວ້ການຄຸ້ມຄອງສຸຂະພາບຂອງທ່ານ ຫຼື ຊ່ວຍເຫຼືອດ້ານຄ່າໃຊ້ຈ່າຍ.ທ່ານມີສິດທີ່ຈະໄດ້ຮັບຂໍ້ມູນນີ້ ແລະ ຄວາມຊ່ວຍເຫຼືອໃນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ. ໂທຫາເບີ (800) 362 3310. TTY / TDD: 711 / (800) 877 8973.