

Employee application Minnesota groups

Please complete entire form in BLACK INK

HMO



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)

<input type="checkbox"/> New	Employee's Last name	First name	MI
<input type="checkbox"/> Change			

Social Security Number or Tax ID Number (SSN/TIN is required for IRS tax reporting regarding your health plan. It does not have any impact on your application or enrollment.)

_____ - _____ - _____

Street address	Apt. #	City	State	Zip code	County
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Mailing address (if different)	City	State	Zip code	County
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Date of birth (mm/dd/yyyy)	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital status <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married/Domestic partnership (date ____/____/____)
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Language (preferred spoken and written). Please check one: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Hmong <input type="checkbox"/> German <input type="checkbox"/> Chinese <input type="checkbox"/> American Sign Language <input type="checkbox"/> Other (please specify) _____	Race (defined as a person's identification with one or more social groups). Please select all that apply: <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Declines to answer <input type="checkbox"/> 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: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Declines to answer <input type="checkbox"/> Unavailable
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Primary phone # ()	Cell phone # ()	Opt-In to Text/SMS contact <input type="checkbox"/> Yes <input type="checkbox"/> No
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Email address	Primary care clinic name _____
	Primary care clinic city _____

Plan:

HMO (list group number) _____

Type of coverage: Employee Employee and spouse/domestic partner Employee and children 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/domestic partner/children.

Reason for enrollment: (check appropriate box)

<input type="checkbox"/> New hire	<input type="checkbox"/> Adoption/placement for adoption (date ____/____/____)	<input type="checkbox"/> Return from layoff (date ____/____/____)
<input type="checkbox"/> Loss of other coverage*	<input type="checkbox"/> Add/delete dependents	<input type="checkbox"/> Name change/address change/PCP or NP change
<input type="checkbox"/> Open enrollment	<input type="checkbox"/> Part-time to full-time employment (date of change ____/____/____)	<input type="checkbox"/> Transfer to retiree segment
<input type="checkbox"/> Marriage/domestic partnership (date ____/____/____)	<input type="checkbox"/> COBRA/state continuation	<input type="checkbox"/> Transfer to disability segment
<input type="checkbox"/> Birth (date ____/____/____)	<input type="checkbox"/> Rehire (date ____/____/____)	<input type="checkbox"/> 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 _____/_____/_____
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Employment Status: Active Retired Leave of Absence 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
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Social Security Number or Tax ID Number (SSN/TIN is required for IRS tax reporting regarding your health plan. It does not have any impact on your application or enrollment.)
____ - ____ - ____

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 <input type="checkbox"/> Male <input type="checkbox"/> Female
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Primary care clinic name	Primary care clinic city
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Language (preferred spoken and written). Please check one: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Hmong <input type="checkbox"/> German <input type="checkbox"/> Chinese <input type="checkbox"/> American Sign Language <input type="checkbox"/> Other (please specify) _____	Race (defined as a person's identification with one or more social groups). Please select all that apply: <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Declines to answer <input type="checkbox"/> 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: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Declines to answer <input type="checkbox"/> Unavailable
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IV. Other insurance information

1. Are you or your spouse, domestic partner, 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

Effective date, Part A ____/____/_____	Effective date, Part B ____/____/_____	Medicare beneficiary identifier (MBI)
Effective date, Part C ____/____/_____	Effective date, Part D ____/____/_____	

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 the following information

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.

I understand that if I opt-in to Text/SMS contact, I agree and consent that Quartz and its affiliates may text me at the cell phone number included on this application to help keep me informed about my benefits.

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 domestic partner 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 domestic partner) 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, domestic partnership, 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 domestic partnership. Payment of back premiums for newborns or newly-adopted children is required prior to claims payment.



Notice of Non-Discrimination and Availability of Language Assistance Services and Auxiliary Aids and Services

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 (includes sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity; and sex stereotypes). Quartz does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

We provide reasonable modifications and free appropriate auxiliary aids and services to people with disabilities to communicate effectively with us and to participate in health programs or activities, 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 interpreters
- 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, you can file a grievance with-

Chief Compliance Officer
2650 Novation Parkway
Fitchburg, 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, our Chief 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.

ATTENTION: Free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call (800) 362-3310, TTY: 711 / (800) 877-8973.

Spanish – ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayudas y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al (800) 362-3310. TTY: 711 / (800) 877-8973 o hable con su proveedor.

Chinese – 注意：如果您说[中文]，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 (800) 362-3310. TTY: 711 / (800) 877-8973 或咨询您的服务提供商。

Hmong – LUS CEEV TSHWJ XEEB: Yog hais tias koj hais Lus Hmoob muaj cov kev pub cuam txhais lus pub dawb rau koj. Cov kev pub thiab cov kev pub cuam ntxiv uas tsim nyog txhawm rau muab lus qhia paub ua cov hom ntaub ntawv uas tuaj yeem nkag cuag tau rau los kuj yeej tseem muaj pub dawb tsis xam tus nqi dab tsi ib yam nkaus. Hu rau (800) 362-3310. TTY: 711 / (800) 877-8973 los sis sib tham nrog koj tus kws muab kev saib xyuas kho mob.

Russian – ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону (800) 362-3310. TTY: 711 / (800) 877-8973 или обратитесь к своему поставщику услуг.

Vietnamese – LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số (800) 362-3310. TTY: 711 / (800) 877-8973 hoặc trao đổi với người cung cấp dịch vụ của bạn.

Laotian – ເຊັ່ນຊາບ: ຖ້າທ່ານເວົ້າເພາວົາ ວາວ, ຈະມີບົວການຊ່ວຍດ້ານພາສາລາວແບບບໍ່ເວລົກໃຫ້ທ່ານ. ມີເຄື່ອງຊ່ວຍ ແລະ ການບໍວິການແບບບໍ່ເວລົກທີ່ເຫັນວ່າມີເພື່ອໃຫ້ຂໍ້ມູນໃນຮຸບແບບທີ່ສາມາດຂຶ້ນຕົງໄດ້. ໂພທາບໍ (800) 362-3310. TTY: 711 / (800) 877-8973 ທີ່ມີກັບບໍ່ເວົ້າເພົ້າການຂອງທ່ານ.

German – ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie (800) 362-3310. TTY: 711 / (800) 877-8973 an oder sprechen Sie mit Ihrem Provider.

