

Minnesota Employer Group Application



2650 Novation Parkway • Fitchburg, WI 53713-3399
(800) 362-3310 • Fax (608) 643-2564
QuartzBenefits.com

- ☐ New Group
☐ Renewing Group/Change*

☒ HMO

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 interpret policy terms, 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.

Note: The following limits will be strictly enforced.

Eligible Employees	Participating Employees
2 – 4	1
5 – 6	3
7	4
8 – 9	5
10	6
11+	70%

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.**

* 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.

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? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, is the other group insured by Quartz? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	If Yes, name of Group(s):			
	Do you want coverage for any subsidiaries? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No			
7.	Employer Group Contact Name:			
	Title:	Phone: ()	Email*:	

**Please note that there may be a billing charge if you do not provide an email address for electronic billing.*

Section B – Plan Information

Only for Groups with less than 50 total employees

1.	Quartz Small Group Benefit Plan Name(s): _____ Please write in the plan name exactly how it appears on the rate sheet.
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Section C – Plan Information

1.	Requested effective date: _____ (COVERAGE IS NOT EFFECTIVE UNTIL WE NOTIFY YOU IN WRITING)
2.	Hourly requirement: <input type="checkbox"/> 30 hours (Default) <input type="checkbox"/> 20 hours
3.	Do you currently have any former employees who have elected coverage and are covered under COBRA or state continuation? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, indicate names of individuals and their expiration dates:
4.	If your company is exempt from state workers' compensation requirements, check here: <input type="checkbox"/>
5.	Percent of medical insurance premium paid by Employer: Single: _____% (Minimum Requirement for Small Groups is 50%) Family: _____%

6.	Are you requesting a Health Reimbursement Arrangement? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of vendor: _____
7.	Probationary Period for new employees (May not exceed 90 calendar days) First of the month following: <input type="checkbox"/> 0 days <input type="checkbox"/> 30 days <input type="checkbox"/> 60 days <div style="text-align: center; margin: 5px 0;">OR</div> Immediately following: <input type="checkbox"/> 0 days <input type="checkbox"/> 30 days <input type="checkbox"/> 60 days <input type="checkbox"/> 90 days
8.	Is the probationary period the same as listed in question 7 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: <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain eligibility guidelines: _____ <hr/> Return from leave of absence within 12 months: <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain eligibility guidelines: _____ <hr/> Return from layoff within 12 months: <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain eligibility guidelines: _____ <hr/> Rehire within 6 months: <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain eligibility guidelines: _____ <hr/> Would you like the probationary period waived for initial enrollment? <input type="checkbox"/> Yes <input type="checkbox"/> No
ONLY FOR GROUPS WITH MORE THAN 50 TOTAL EMPLOYEES	
9.	Is this coverage part of a union negotiated agreement? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Next Union Contract Review Date: _____ <div style="text-align: right; font-size: small;">(Month/Day/Year)</div>
10.	Nature of Business: _____
11.	How long has your company been in business? _____
12.	Are you applying for replacement of your current group medical coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, you must furnish the following information: <hr/> <div style="display: flex; justify-content: space-between;"> Name of current group carrier: _____ Original effective date: _____ Attach your most recent billing statement. </div>
13.	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): <input type="checkbox"/> Effective date of rehire <input type="checkbox"/> Effective first of the month following rehire * The employee termination date will be the first of the month following the date of termination.
14.	Do you have variable hour employees? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain eligibility guidelines: _____
15.	Are you requesting domestic partner coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No
Section D – Retired Employees	
<p>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.</p> <p><input type="checkbox"/> Please attach a copy of your eligibility requirements for retiree coverage.</p> <p>Indicate names of individuals: _____</p>	
Section E – Agent/Agency Information	
<input type="checkbox"/> Direct Sale, skip the Agent of Record Information. Don't forget to sign the application.	
<input type="checkbox"/> 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 termination provisions.

Dated: _____ Agent's Name: _____
(Month/Day/Year) (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: <input type="checkbox"/> Yes <input type="checkbox"/> No
<i>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.</i> |
| 2. | Enter the average number of employees working at least 20 hours per week on business days during the preceding calendar year, excluding employees whose health coverage is determined by a collective bargaining agreement, and excluding individuals working on a temporary, seasonal or substitute basis. <i>*The number of employees should not include retirees and disabled former employees required to be covered.</i> (include all locations): _____
<i>* Collective Bargaining Agreement: If the group insured is a collective bargaining unit, only count employees who are part of the collective bargaining unit. Do not count other employees in the company.</i> |
| 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.

<input type="checkbox"/> 2-19 employees <input type="checkbox"/> 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)



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 ayuda 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 pab cuam txhais lus pub dawb rau koj. Cov kev pab thiab cov kev pab 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 pab 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 – ຄຳມອບ: ຖ້າທ່ານເວົ້າພາສາ ລາວ, ຈະມີບໍລິການຊ່ວຍດ້ານພາສາແບບບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ມີເຄື່ອງຊ່ວຍ ແລະ ການບໍລິການແບບບໍ່ເສຍຄ່າທີ່ເໝາະສົມເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້. ໂທຫາເບີ (800) 362-3310. TTY: 711 / (800) 877-8973 ຫຼື ລົມກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ.
German – ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistentendienste 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.

