

Employee application Wisconsin groups



Please complete entire form in BLACK INK

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

- HMO offered by Quartz Health Benefit Plans Corporation
- POS offered by Quartz Health Benefit Plans Corporation
- PPO offered by Quartz Health Benefit Plans Corporation

I. Employee information (Please do not use abbreviations or nicknames on this application)

Employee'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.) _____ - _____ - _____

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 (date: ____/____/____) <input type="checkbox"/> Domestic partnership (date: ____/____/____)	Primary phone number (____) _____
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Height/Weight	Email
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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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Plan: HMO POS PPO

Type of coverage Employee Employee and spouse/partner in civil union 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.

Primary care clinic name	Primary care clinic city
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II. Employer information

Requested effective date of coverage ____/____/____

Date employed ____/____/____ Hours employee works per week on average

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

Name of employer group

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 <small>(SSN/TIN is required for IRS tax reporting regarding your health plan.)</small> _____ - _____ - _____		
Does dependent live at the same address as you? <input type="checkbox"/> Yes <input type="checkbox"/> 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
Primary care clinic name	Primary care clinic city	
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Note: If you are waiving your right to this group coverage, you do not need to complete the General information and medical information.

IV. General information and medical information

- 1. Have you or any dependent ever been insured by Quartz? Yes No
If yes, give subscriber name _____ Dates previously covered by Quartz _____
- 2. Will you or any of your dependents continue to have other insurance after the Quartz effective date of this policy? Yes No
If yes, complete the following information:
Name(s) of insured _____ Employer _____
Insurance company _____ Insurance company phone # _____
Subscriber # _____ Group # _____
Effective date of coverage _____
- 3. Are you or any family member(s) enrolled in Medicare? Yes No
If yes, please answer the following and attach a copy of your Medicare card.
Name _____ Name _____
Medicare # _____ Medicare # _____
Effective date, part A _____ Effective date, part A _____
Effective date, part B _____ Effective date, part B _____
Effective date, part C (Medicare advantage) _____ Effective date, part C (Medicare advantage) _____
Effective date, part D _____ Effective date, part D _____
Reason for Medicare: Age 65 Disability End stage renal disease Disability and ESRD
- 4. Are you or any dependent now disabled or unable to perform normal activities? Yes No
If yes, name of person _____ Type of disability _____ Date of disability _____
- 5. Have you or any dependent incurred health claims in excess of \$5,000 during the last 24 months? Yes No
If yes, name of person _____ Reason _____
- 6. Within the last 24 months have you or any dependent listed above consulted about, received treatment for or been diagnosed with: cancer, stroke, diabetes, heart condition (including hypertension), vascular disease, behavioral health (mental, anxiety or emotional disorder), muscular or systemic disease (such as arthritis or lupus), alcohol or drug use, liver, kidney, lung (such as COPD or asthma) or intestinal disorder? Yes No
If yes, please explain on a separate sheet of paper and attach to this form. (You do not need to report genetic tests or test results.)
- 7. Have you ever been diagnosed by a member of the medical profession as having an immune system disorder, AIDS or ARC? Yes No
(You do not need to report HIV test results.)
- 8. Are you or any dependents currently taking any medications? Yes No
If yes, please list the medications _____

- 9. Are you or is any dependent listed above pregnant? Yes No
If yes, name(s) _____ Pregnancy due date _____
- 10. Have you or has any listed dependent scheduled or had any surgeries in the last 12 months? Yes No
Have you or has any listed dependent been hospitalized in the last 12 months? Yes No
Reason for hospitalization or surgery _____
- 11. Are you or any dependents listed above involved in a Workers Compensation case? Yes No
If yes, indicate family member involved and start date/accident date _____
Insurance company name _____

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.

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/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, if my employer has an open enrollment period.

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



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 ntauv 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 - ຄຳທ່ານເວົ້າພາສາ 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.

