

# 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	
Social Security Number or Tax ID Number <small>(SSN/TIN is required for IRS tax reporting regarding your health plan.)</small> _____ - _____ - _____					
Street address		Apt. #	City	State	ZIP code
Mailing address (if different)		City	State	ZIP code	County
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 (____) _____	
Height/Weight		Email			
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	
Plan: <input type="checkbox"/> HMO <input type="checkbox"/> POS <input type="checkbox"/> 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

## 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 <b>No</b> 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](mailto: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](https://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](https://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](https://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.**

<b>Spanish</b> – 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.
<b>Chinese</b> – 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。
<b>Hmong</b> – 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.
<b>Russian</b> – 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.
<b>Vietnamese</b> – 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.
<b>Laotian</b> – ຄຳມອບ: ຖ້າທ່ານເວົ້າພາສາ ລາວ, ຈະມີບໍລິການຊ່ວຍດ້ານພາສາແບບບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ມີເຄື່ອງຊ່ວຍ ແລະ ການບໍລິການແບບບໍ່ເສຍຄ່າທີ່ເໝາະສົມເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້. ໂທຫາໂຕຈີ (800) 362-3310. TTY: 711 / (800) 877-8973 ຫຼື ລົມກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ.
<b>German</b> – 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.

