2026 Individual insurance election form — Quartz Select Network

Offered by:
Quartz Health Plan MN Corporation

2650 Novation Parkway • Fitchburg, WI 53713-3399
(800) 926-8227 • Fax (608) 471-4394
QuartzBenefits.com

In order to enroll in Quartz individual insurance coverage, you will need to complete the applicant information and the individual insurance election form

Requested coverage effective date _____/_____/2026

1. Plan options: (Please select a plan type)

☐ Gold $4,000 Ded (Vision) ☐ Gold Maintenance $700 Ded (Vision) ☐ Easy Compare Gold Flat Rx Copays (Vision) ☐ Gold $4,000 Ded (Dental & Vision) ☐ Gold Maintenance $700 Ded (Dental & Vision) ☐ Easy Compare Flat Rx Copays (Dental & Vision)
☐ Silver $8,000 Ded (Vision) ☐ Silver $0 Ded Flat Rx Copays (Vision) ☐ Easy Compare Silver (Vision) ☐ Silver $8,000 Ded (Dental & Vision) ☐ Silver $0 Ded Flat Rx Copays (Dental & Vision) ☐ Easy Compare Silver (Dental & Vision)
☐ Bronze $10,000 Ded (Vision) Flat Rx Copays ☐ Bronze $8,200 HSA (Vision) ☐ Easy Compare Bronze (Vision) ☐ Bronze $10,000 Ded Flat Rx Copays (Dental & Vision) ☐ Easy Compare Bronze (Dental & Vision)
☐ Catastrophic (Vision)

Is this a child-only policy? ☐ Yes ☐ No	If yes, are you the legal guardian or custodial parent? ☐ Yes ☐ No Legal guardian or custodial parent name: _____

Pediatric dental services

This policy does not include pediatric dental services as required under the federal Patient Protection and Affordable Care Act. This coverage is available in the insurance market and can be purchased as a standalone product. Please contact your insurance carrier, agent, or MNsure.org if you wish to purchase pediatric dental coverage or a stand-alone dental services product.

☐ *By checking this box I acknowledge I am electing coverage that does not include pediatric dental services as required under the federal Patient Protection and Affordable Care Act. I have purchased an Exchange certified stand-alone dental plan.*

For plan descriptions, please visit QuartzBenefits.com or call Quartz Customer Success at (800) 362-3310.
**The combined family dental option is not available.*

2. Primary care clinic – If there is not enough space provided, please attach information for any additional applicants on a separate page.

Applicant			☐ Yes ☐ No
Person 2			☐ Yes ☐ No
Person 3			☐ Yes ☐ No
Person 4			☐ Yes ☐ No

3. Enrollment reason – Note: Additional documentation may be required.

☐ Open enrollment

Are you enrolling with access to an ICHRA or QSERA? ☐ Yes ☐ No If yes, date eligible for ICHRA/QSERA: _____/_____/_____

☐ Special enrollment Event date _____/_____/_____

Please select one:

○ Loss of other coverage (including COBRA) Prior carrier name: _____ Phone number: _____

☐ I attest that I did not lose coverage due to non-payment of premium or voluntary termination during my plan year.

○ Permanent move Prior carrier name: _____ Phone number: _____

○ Birth/Adoption/Foster care

○ Marital status change

○ Other _____

4. Other insurance information

Does anyone applying for coverage currently have other health insurance, including Medicare? ☐ Yes ☐ No

If yes, please fill in your insurance information below:

Current insurance provider: _____ Phone number: _____

Policyholder: _____

List all individuals covered under this policy: _____

Member ID number(s): _____

Termination date (if applicable): _____

☐ The coverage I am applying for on this application is intended to replace the coverage listed above.

5. Invoice and payment options

Applicants will receive a paper invoice in the mail. Acceptable forms of payment include paper checks, cashier's checks, money orders, credit cards, and all general-purpose pre-paid debit cards. You can also arrange one-time or recurring Automated Clearing House (ACH) payments by contacting our Customer Success team at (800) 362-3310.

Applicant's full name (please print): _____ Date: _____

Applicant's signature: _____

Applicant information

Step 1: Tell us about yourself. (We'll need one adult in the family to be the contact person for your application.)

1. First name, Middle name, Last name, and Suffix:

2. Home address:			3. Apartment or suite number:
4. City:	5. State:	6. ZIP code:	7. County:
8. Mailing address (if different from home address):			9. Apartment or suite number:
10. City:	11. State:	12. ZIP code:	13. County:

14. Cell phone number:	15. Other phone number:

16. Email address:

17. Do you need health coverage?

☐ Yes ☐ No

18. Social Security Number (SSN) or Taxpayer Identification Number (TIN)*: _____ – _____ – _____	19. Sex: ☐ Male ☐ Female	20. Date of birth (mm/dd/yyyy): ____/____/____

21. Do you use tobacco (required if age 21+)? ☐ Yes ☐ No

Tobacco use is defined as use of tobacco on average of four or more times per week in the past six months.

22. Language (preferred spoken and written). Please check one:

☐ English ☐ Chinese
☐ Spanish ☐ American Sign Language
☐ Hmong ☐ Other (please specify) _____
☐ German

23. Race (defined as a person's identification with one or more social groups). Please select all that apply:

☐ American Indian or Alaska Native ☐ White
☐ Asian ☐ Declines to answer
☐ Black or African American ☐ Unavailable
☐ Native Hawaiian or other Pacific Islander

24. 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

*Failure to provide a Social Security Number will not affect the processing of your application.

Applicant information

Step 2: Tell us about anyone else who needs health coverage.

(If you have more people to include, make a copy of this page and attach.)

Step 2: Person 2

1. First name, Middle name, Last name, and Suffix:

2. Relationship to you:

3. Social Security Number (SSN) or Taxpayer Identification Number (TIN):

_____ – _____ – _____

4. Sex:

☐ Male ☐ Female

5. Date of birth (mm/dd/yyyy):

____/____/____

6. Cell phone number:

7. Email address:

8. Does person 2 live at the same address as you? ☐ Yes ☐ No If **no**, list address:

9. Does person 2 use tobacco (required if age 21+)? ☐ Yes ☐ No

Tobacco use is defined as use of tobacco on average of four or more times per week in the past six months.

10. Language for person 2 (preferred spoken and written). Please check one:

☐ English
☐ Spanish
☐ Hmong
☐ German
☐ Chinese
☐ American Sign Language
☐ Other (please specify)

_____

11. Race for person 2 (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 other Pacific Islander
☐ White
☐ Declines to answer
☐ Unavailable

12. Ethnicity for person 2 (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

Step 2: Person 3

1. First name, Middle name, Last name, and Suffix:

2. Relationship to you:

3. Social Security Number (SSN) or Taxpayer Identification Number (TIN):

_____ – _____ – _____

4. Sex:

☐ Male ☐ Female

5. Date of birth (mm/dd/yyyy):

____/____/____

6. Cell phone number:

7. Email address:

8. Does person 3 live at the same address as you? ☐ Yes ☐ No If **no**, list address:

9. Does person 3 use tobacco (required if age 21+)? ☐ Yes ☐ No

Tobacco use is defined as use of tobacco on average of four or more times per week in the past six months.

10. Language for person 3 (preferred spoken and written). Please check one:

☐ English ☐ Chinese
☐ Spanish ☐ American Sign Language
☐ Hmong ☐ Other (please specify)
☐ German _____

11. Race for person 3 (defined as a person's identification with one or more social groups). Please select all that apply:

☐ American Indian or Alaska Native ☐ White
☐ Asian ☐ Declines to answer
☐ Black or African American ☐ Unavailable
☐ Native Hawaiian or other Pacific Islander

12. Ethnicity for person 3 (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

Step 2: Person 4

1. First name, Middle name, Last name, and Suffix:

2. Relationship to you:

3. Social Security Number (SSN) or Taxpayer Identification Number (TIN):

_____ – _____ – _____

4. Sex:

☐ Male ☐ Female

5. Date of birth (mm/dd/yyyy):

____/____/____

6. Cell phone number:

7. Email address:

8. Does person 4 live at the same address as you? ☐ Yes ☐ No If **no**, list address:

9. Does person 4 use tobacco (required if age 21+)? ☐ Yes ☐ No

Tobacco use is defined as use of tobacco on average of four or more times per week in the past six months.

10. Language for person 4 (preferred spoken and written). Please check one

☐ English ☐ Chinese
☐ Spanish ☐ American Sign Language
☐ Hmong ☐ Other (please specify)
☐ German _____

11. Race for person 4 (defined as a person's identification with one or more social groups). Please select all that apply:

☐ American Indian or Alaska Native ☐ White
☐ Asian ☐ Declines to answer
☐ Black or African American ☐ Unavailable
☐ Native Hawaiian or other Pacific Islander

12. Ethnicity for Person 4 (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

Applicant information

Step 3: Read and sign this application.

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 in step 6 of this application. 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 intentional misrepresentation of a material fact relied upon by the insurer may be used to deny a claim. I further understand that this contract can be voided if it is determined that I or a family member 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.

Signature: _____ Date signed: _____

Step 4: Mail or email your completed application.

Mail your completed application to:
Quartz - Sales Department
2650 Novation Parkway
Fitchburg, WI 53713

Scan and email your completed application to:
IndividualSales@QuartzBenefits.com

Applicant information

Step 5: **Please sign the Notice to Applicant.**

NOTICE TO APPLICANT
REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

According to the information furnished by you on your application for insurance coverage, you intend to lapse or otherwise terminate your present policy and replace it with a policy to be issued by Quartz. For your own information and protection, certain facts should be pointed out to you which should be considered before you make this change.

1. Questions in the application for the new policy must be answered truthfully and completely; otherwise, the validity of the policy and the payment of any benefits thereunder may be voided.

2. The new policy will be issued at a higher age than that used for issuance of your present policy; therefore, the cost of the new policy, depending upon the benefits, may be higher than you are paying for your present policy.

3. The renewal provisions of the new policy should be reviewed so as to make sure of your rights to periodically renew the policy.

4. It may be to your advantage to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. You should be certain that you understand all the relevant factors involved in replacing your present coverage.

The above "Notice to Applicant" was delivered to me on _____.
(Date)

Signature of applicant:_____

Printed name of agent: _____ Date: _____

Agency name: _____ National producer number: _____

Signature of agent: _____

PLEASE KEEP A COPY OF THIS NOTICE FOR YOUR FILES.

Applicant information

Step 6: Assistance with completing this application (if applicable)

YOU CAN CHOOSE AN AUTHORIZED REPRESENTATIVE.

You can give a trusted person permission to talk about this application with us, see your application and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative." If you ever need to change your authorized representative, contact us. If you're a legally appointed representative for someone on this application, submit proof with the application.

1. First name, Middle name, Last name, and Suffix:

2. Address:	3. Apartment or suite number:

4. City:	5. State:	6. ZIP code:

7. Phone number:

8. Organization name:	9. ID number (if applicable):

By signing, you allow this person to sign your application, get official information about this application, and act for you on all future matters with this agency.

10. Signature:	11. Date (mm/dd/yyyy) _____/_____/_____

FOR CERTIFIED APPLICATION COUNSELORS, NAVIGATORS, AGENTS, AND BROKERS ONLY.

Complete this section if you're a certified counselor, navigator, agent, or broker filling out this application for someone else.

1. Application start date (mm/dd/yyyy):

2. First name, Middle name, Last name, and Suffix:

3. Organization name:	4. ID number (if applicable):

Quartz is a Qualified Health Plan issuer in the Health Insurance Marketplace.
Quartz does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation, or health status in the administration of the plan, including enrollment and benefit determinations.