In partnership with

Quartz | GUNDERSEN HEALTH SYSTEM®

Minnesota

OMB No. 0938-1378
Expires: 7/31/2024

Individual Enrollment Request Form to Enroll in a Medicare Advantage Plan (Part C) or Medicare Prescription Drug Plan (Part D)

Who can use this form?

People with Medicare who want to join a Medicare Advantage Plan or Medicare Prescription Drug Plan

To join a plan, you must:

- Be a United States citizen or be lawfully present in the U.S.
- Live in the plan's service area

Important: To join a Medicare Advantage Plan, you must also have both:

- Medicare Part A (Hospital Insurance)
- Medicare Part B (Medical Insurance)

When do I use this form?

You can join a plan:

- Between October 15 – December 7 each year (for coverage starting January 1)
- Within 3 months of first getting Medicare
- In certain situations where you're allowed to join or switch plans
- Visit Medicare.gov to learn more about when you can sign up for a plan

What do I need to complete this form?

- Your Medicare Number (the number on your red, white, and blue Medicare card)
- Your permanent address and phone number

Note: You must complete all items in Section 1. The items in Section 2 are optional — you can't be denied coverage because you don't fill them out.

Reminders:

- If you want to join a plan during fall open enrollment (October 15–December 7), the plan must get your completed form by December 7.
- Your plan will send you a bill for the plan's premium. You can choose to sign up to have your premium payments deducted from your bank account or your monthly Social Security (or Railroad Retirement Board) benefit.

What happens next?

Send your completed and signed form to:
Quartz Medicare Advantage (HMO)
2650 Novation Parkway
Madison, WI 53713
Once they process your request to join, they'll contact you.

How do I get help with this form?

Call a Quartz Champion at **(800) 394-5566**. TTY users can call **711**. Or, call Medicare at **1-800-MEDICARE (1-800-633-4227)**. TTY users can call **1-877-486-2048**.

En español: Llame a Quartz Medicare Advantage al **(800) 394-5566/TTY 711** o a Medicare gratis al **(1-800-633-4227)** y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1378. The time required to complete this information is estimated to average 20 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

IMPORTANT

Do not send this form or any items with your personal information (such as claims, payments, medical records, etc.) to the PRA Reports Clearance Office. Any items we get that aren't about how to improve this form or its collection burden (outlined in OMB 0938-1378) will be destroyed. It will not be kept, reviewed, or forwarded to the plan. See "What happens next?" on this page to send your completed form to the plan.

Effective Date: 01/01/2023
H9834_22 08_C CMS ACCEPTED 08/23/2022

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Quartz Medicare Advantage (HMO)
2650 Novation Parkway, Madison, WI 53713
(800) 394-5566 or TTY 711 • Fax (608) 881-8327
QuartzBenefits.com/MedicareAdvantage

2023 Enrollment Application

Effective Date: _____

ELECTION TYPE (PLEASE CHECK ONE.)

- ☐ Annual Election Period (AEP) from Oct. 15 – Dec. 7, 2022
- ☐ Open Enrollment Period from January 1 – March 31, 2023
- ☐ Initial Coverage Election Period (ICEP)
- ☐ 5-Star Quality Rating Special Enrollment Period (SEP) from Dec. 8, 2022, to Nov. 30, 2023
- ☐ Open Enrollment Period for Institutionalized Individuals (OEPI)
- ☐ Special Enrollment Period (Complete SEP Attestation attached)

To enroll in Quartz Medicare Advantage (HMO), please provide the following information:

YOUR PERSONAL INFORMATION

Last Name:	First Name:	MI:

Date of Birth: (MM/DD/YYYY)	Gender:	Home Phone Number:	Alternate Phone Number:

Email address: _____

- ☐ Opt in to receiving email communication.
- ☐ Opt out of receiving email communication.

PERMANENT RESIDENCE STREET ADDRESS (P.O. BOX IS NOT ALLOWED.)

Street Address:

City:	State:	ZIP:

County:

MAILING ADDRESS (ONLY IF DIFFERENT FROM YOUR PERMANENT RESIDENCE STREET ADDRESS.)

Address:

City:	State:	ZIP:

TEXT MESSAGE COMMUNICATIONS PREFERENCE (CHECK ONE.)

Mobile phone number: _____

- ☐ Opt in to receiving text messages.
- ☐ Opt out of receiving text messages.

Text messaging will be limited to outreach. Message and data rates may apply.

Minnesota

PLEASE PROVIDE YOUR MEDICARE INSURANCE INFORMATION

Please take out your red, white, and blue Medicare card to complete this section.

Fill out this information as it appears on your Medicare card.

-OR-

Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

Name (as it appears on your Medicare card):

Medicare Number:

Is entitled to:	Effective Date:
HOSPITAL (Part A):	MEDICAL (Part B):

You must have Medicare Parts A and B to join a Medicare Advantage plan.

I AM APPLYING FOR:

Quartz Medicare Advantage (HMO)

- ☐ **Value** (no Rx) $0.00 monthly premium plan
- ☐ **Elite** (no Rx) $120.00 monthly premium plan
- ☐ **Core D** (with Rx) $0.00 monthly premium plan
- ☐ **Value D** (with Rx) $43.00 monthly premium plan
- ☐ **Elite D** (with Rx) $152.00 monthly premium plan

OPTIONAL SUPPLEMENTAL DENTAL BENEFIT*

☐ Yes, I would like to buy the supplemental dental benefit option for an additional $38.00 per month.

WHO IS YOUR PRIMARY CARE PROVIDER AND WHAT CLINIC DO YOU GO TO FOR CARE? (OPTIONAL)

Primary Care Provider (please specify):

Clinic Name (please specify):

HOW DID YOU HEAR ABOUT QUARTZ MEDICARE ADVANTAGE?

- ☐ Agent/Broker
- ☐ Aging and Disability Resource Center (ADRC)
- ☐ Employer
- ☐ Facebook
- ☐ Friend/Relative
- ☐ Internet
- ☐ Mailing
- ☐ Newspaper
- ☐ Provider Referral
- ☐ Radio
- ☐ Television

PREFERRED LANGUAGE? (Spoken and written. Please check one.)

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

RACE: Defined as a person's identification with one or more social groups.
At Quartz Medicare Advantage, we are deeply concerned about racial and ethnic disparities in health outcomes. It's important we do everything we can to promote equitable health care for all. Please complete this survey. We value your feedback and respect your rights. Participation is voluntary, and your answers are confidential and protected by law.

- ☐ American Indian or Alaska Native
- ☐ Asian Indian
- ☐ Black or African American
- ☐ Chinese
- ☐ Filipino
- ☐ Guamanian or Chamorro
- ☐ Japanese
- ☐ Korean
- ☐ Native Hawaiian
- ☐ Other Asian
- ☐ Other Pacific Islander
- ☐ Samoan
- ☐ Vietnamese
- ☐ White
- ☐ I choose not to answer

ETHNICITY: Refers to shared cultural characteristics such as language, ancestry, practices, and beliefs.

- ☐ Not of Hispanic, Latino/a or Spanish origin
- ☐ Puerto Rican
- ☐ Another Hispanic, Latino or Spanish origin
- ☐ Mexican, Mexican American, Chicano/a
- ☐ Cuban
- ☐ I choose not to answer

OTHER FORMATS REQUESTED FOR MEMBER MATERIALS?

☐ Audio Recording ☐ Large Print

PLEASE ANSWER THE FOLLOWING QUESTIONS TO HELP MEDICARE COORDINATE YOUR BENEFITS:

1. Are you a resident of a long-term care facility, such as a nursing home? ☐ Yes ☐ No
2. Are you enrolled in your State Medicaid program? ☐ Yes ☐ No
   - If yes, please provide your Medicaid number: _____
   - To be completed by agent. Medicaid verified? ☐ Yes ☐ No
     Who verified? _____
3. Do you, on your own or through your spouse, have any medical or health insurance other than Medicare, such as private insurance or Workers' Compensation? ☐ Yes ☐ No
   - If yes, what is the name of your insurance? _____
   - Type of Insurance: ☐ Group ☐ Individual ☐ Medicare Supp ☐ Other:_____
   - Are you or your spouse actively working? ☐ Yes ☐ No
   - Effective date of coverage: _____ Group size of employer: ☐ 1-19 ☐ 20+
4. Will you be keeping this health insurance in addition to Quartz Medicare Advantage?
   ☐ Yes ☐ No
   - **If no,** please provide the end date of the other coverage: _____

Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal Employee Health Benefits coverage, VA Benefits, Senior Care, or State pharmaceutical assistance programs.

5. Will you have other prescription drug coverage in addition to Quartz Medicare Advantage?
   ☐ Yes ☐ No
   - If yes, name of the other drug coverage: _____
   - ID# for drug coverage: _____
   - Group # for drug coverage: _____

UNDERSTANDING YOUR PLAN

By initialing to the right, you are certifying that you have read and understood all of the statements below. You must agree to all of these terms to enroll in Quartz Medicare Advantage.

Initial Here _____

1. I must keep Hospital (Part A) and Medical (Part B) to stay enrolled in Quartz Medicare Advantage.
2. I understand that people with Medicare aren't usually covered under Medicare while out of the country; however, as a Quartz Medicare Advantage member, I'm covered anywhere in the world for urgent and emergency services.
3. I must get all my health care services from Quartz Medicare Advantage network providers, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Quartz Medicare Advantage and other services contained in my Evidence of Coverage document will be covered. Without authorization, NEITHER MEDICARE NOR QUARTZ MEDICARE ADVANTAGE WILL PAY FOR THE SERVICES.
4. Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug plan options, medical assistance through the State Medicaid program, and the Medicare Savings Program.
5. By joining this Quartz Medicare Advantage plan or Medicare Prescription Drug plan, I acknowledge that Quartz Medicare Advantage will share my information with Medicare, who may use it to track my enrollment to make payments, and for other purposes allowed by federal law that authorize the collection of this information (see Privacy Act Statement on Page 7).
6. I understand that if I don't have Medicare prescription drug coverage or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty in addition to my premium for Medicare prescription drug coverage in the future.
7. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
8. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.
9. I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I've read and understood the application's content. If signed by an authorized representative (as described above), this signature certifies that: 1) This person is authorized under state law to complete this enrollment; and 2) Documentation of this authority is available upon request by Medicare.

PAYING YOUR PLAN PREMIUM

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) with an automatic checking or savings account deduction. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month. If you are assessed a Part D Income Related Monthly Adjustment Amount (IRMAA), you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or RRB. DO NOT pay Quartz Medicare Advantage the Part D-IRMAA.

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at socialsecurity.gov/prescriptionhelp.

If you qualify for Extra Help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover. If you don't select a payment option, you will get an invoice.

PLEASE SELECT A PREMIUM PAYMENT OPTION

☐ **Automatic deduction – Checking or savings account**
(complete Automatic Payment Authorization Form)

- By selecting this option, I authorize Quartz Medicare Advantage (HMO) to initiate electronic fund transfers drawn on my bank account, on the fourth business day of the month, for the payment of my plan premium. I further authorize the bank to debit my bank account on or about the fourth business day of the month.
- I realize that my bank shall be under no obligation to furnish me with any special advice or notice of the payment of any such transaction, other than my monthly bank statement. I realize the electronic funds transfers will begin approximately 30 days after submitting this request. The effective date will be the date shown on the written confirmation I will receive from Quartz Medicare Advantage.
- I understand that if for any reason funds are not available for withdrawal in the account listed on this form, Quartz Medicare Advantage reserves the right to change my billing method to direct billing by sending me an invoice and requiring that my payments be made by check or money order.

☐ **Automatic deduction – Monthly Social Security benefit check**

☐ **Automatic deduction – Monthly Railroad Retirement Board benefit check**

- The Social Security/Railroad Retirement Board deduction may take two or more months to begin.
- We will send you a confirmation letter with the effective date of this deduction. You are responsible for payment before the effective date of this automatic deduction.
- If Social Security/Railroad Retirement Board does not approve your request for automatic deduction, we will send you an invoice for your monthly premiums.

☐ **I will make my own payments – Monthly or Recurring payments**

- Select this option if you choose to pay with a check, credit card, or electronic payments from your checking or savings account that are initiated by you on a monthly or recurring basis. Note: You will receive an invoice with this option. You may submit payment via check or money order using the invoice.

COMPLETE THIS PAYMENT AUTHORIZATION FORM IF ELECTING AUTOMATIC DEDUCTION FROM BANK ACCOUNT

Your Bank Name:

_____

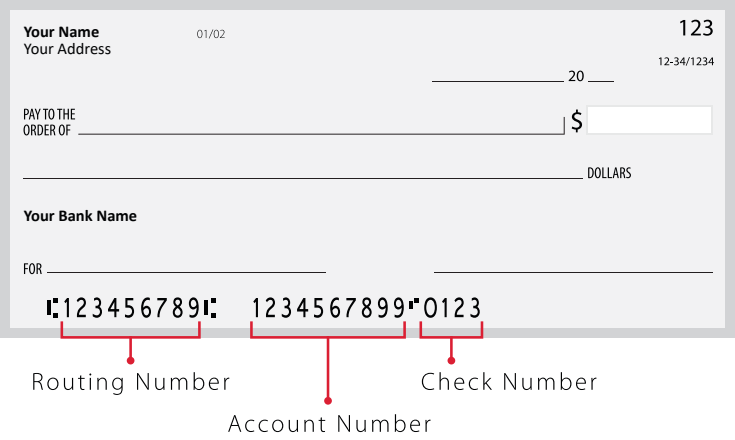
Routing Number:

_____

Account Number:

_____

☐ Checking ☐ Savings



READ THIS IMPORTANT INFORMATION

If you are a member of a Medicare Advantage Plan (like an HMO or PPO), you may already have prescription drug coverage from your Medicare Advantage plan that will meet your needs. By joining Quartz Medicare Advantage, your membership in your Medicare Advantage plan may end. This will affect both your doctor and hospital coverage as well as your prescription drug coverage. Read the information that your Medicare Advantage plan sends you and if you have questions, contact your Medicare Advantage plan.

If you currently have health coverage from an employer or union, joining Quartz Medicare Advantage could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Quartz Medicare Advantage. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there isn't any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

RELEASE OF INFORMATION

By joining this Medicare health or prescription drug plan, I acknowledge that Quartz Medicare Advantage will release my information to Medicare and other plans as is necessary for treatment, payment, and health care operations. I also acknowledge that Quartz Medicare Advantage will release my information including my prescription drug event data to Medicare, who may release it for research and other purposes, which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the state where I live) on this application means that I have read and understood the contents of this application. If signed by an authorized individual (as described above) this signature certifies that 1) this person is authorized under state law to complete this enrollment; and 2) documentation of this authority is available upon request from Quartz Medicare Advantage or Medicare.

Signature: _____ Today's Date: _____

If you are the authorized representative, you must sign the release on Page 6 and provide the following information. A completed Financial Power of Attorney form is required to complete the application. Include with the application and mail all documents to the address listed below.

Last Name:	First Name:	MI:

Address:

Relationship to Enrollee:	Phone Number:

AGENT USE ONLY

☐ I understand that I must complete and retain a Scope of Appointment for all sales for the required period of 10 years. I do not need to submit a copy of the Scope of Appointment to Quartz, but Quartz may request a copy of any Scope of Appointment associated with an application, at any time. I understand that I am required to respond timely and cooperate with any requests and disciplinary action, including non-compensation, will be taken if I cannot produce a valid Scope of Appointment.

Name of Staff Member/Agent/Broker (if assisted in enrollment):

Additional Comments:

Submit this application to:

Quartz Medicare Advantage
2650 Novation Pkwy
Madison, WI 53713

Or by email at: **MedicareAdvantage@QuartzBenefits.com**

Call a Quartz Champion at **(800) 394-5566.**
For people who are deaf, hard of hearing or speech impaired, **call TTY 711.**
Monday - Friday, 8 a.m. - 8 p.m.
October 1 - March 31, seven days a week from 8 a.m. - 8 p.m.

PRIVACY ACT STATEMENT The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) or Prescription Drug Plans (PDP), improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50, 422.60, 423.30 and 423.32 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

Complete only if enrolling using a SEP election.

ATTESTATION OF ELIGIBILITY FOR AN ENROLLMENT PERIOD

Typically, you may enroll in a Medicare Advantage plan only during the Annual Enrollment Period (AEP) from Oct. 15-Dec. 7 of each year. However, some exceptions may allow you to enroll in a Medicare Advantage plan outside of the AEP. Please read the following statements carefully, and check the box next to the one that applies to you. By checking any of the following boxes, you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

☐ I am new to Medicare.

☐ I am enrolled in a Medicare Advantage Plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).

☐ I currently have a Medicare plan and want to enroll under the 5-Star SEP in this Medicare Advantage plan with a 5-Star Rating during the same year as my enrollment. I can use this SEP only one time a year. Effective dates are the first of the month from Jan. 1-Dec. 1, during the year of the plan's 5-Star Rating designation.

☐ I recently moved outside of the service area for my current plan or I recently moved, and this plan is a new option for me. I moved on (insert date) _____.

☐ I recently was released from Incarceration. I was released on (insert date) _____.

☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) _____.

☐ I recently obtained lawful presence status in the United States. I got this status on (insert date) _____.

☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date) _____.

☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (insert date) _____.

☐ I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.

☐ I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long-term care facility). I moved/will move into/out of the facility on (insert date) _____.

☐ I recently left a PACE program on (insert date) _____.

☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date) _____.

☐ I am leaving my employers or union's coverage on (insert date) _____.

ATTESTATION OF ELIGIBILITY FOR AN ENROLLMENT PERIOD

☐ I belong to a pharmacy assistance program provided by my state.

☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.

☐ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date) _____.

☐ I was enrolled in a Special Needs Plan (SNP) but I lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date) _____.

☐ I was affected by an emergency or a major disaster (as declared by the Federal Emergency Management Agency, or by Federal, my state, or my local government). One of the other statements on this page applied to me, but I was unable to make my request because of the disaster.

If none of these statements apply to you or you're not sure you're eligible to enroll, please call a Quartz Champion at (800) 394- 5566 (TTY: 711).