

Employee Application



Please Complete Entire Form in BLACK INK

Underwritten by
Unity Health Plans Insurance Corporation
840 Carolina Street • Sauk City, WI 53583-1374
(800) 362-3309 • Fax (608) 643-2564
QuartzBenefits.com

I. EMPLOYEE INFORMATION (Please do not use abbreviations or nicknames on this application)

<input type="checkbox"/> New <input type="checkbox"/> Change	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	County
Mailing Address (if different)		City	State	Zip Code	County	
Date of Birth ____/____/____	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <small>(provide date when marriage occurred)</small>	Primary Language Spoken <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other			
Home Phone # ()		Work Phone # ()				
Cell Phone # ()		Applicant's E-Mail Address:				
Plan Requested: <input type="checkbox"/> HMO <input type="checkbox"/> POS <input type="checkbox"/> PPO		Group Number: _____				
Type of Coverage: <input type="checkbox"/> Employee <input type="checkbox"/> Employee and Spouse <input type="checkbox"/> Employee and Child(ren) <input type="checkbox"/> Family		<input type="checkbox"/> WAIVING COVERAGE (skip to section V. Waiver of Group Coverage)				
*Primary Care Physician (PCP) or Nurse Practitioner (NP) and Clinic			Current Patient <input type="checkbox"/> Yes <input type="checkbox"/> No			
<small>* Confirm your NP can be selected as a PCP at QuartzBenefits.com/findadoctor. If no PCP or NP preference, indicate "ASSIGN".</small>						

II. FOR EMPLOYER USE

Name of Employer Group:	Date Employed: ____/____/____	Weekly Hours:	Requested Effective Date: ____/____/____
Employment Status: <input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> LOA <input type="checkbox"/> COBRA / Continuation Effective Date ____/____/____			
Reason: <input type="checkbox"/> End of Employment <input type="checkbox"/> Death of Employee <input type="checkbox"/> Entitlement to Medicare <input type="checkbox"/> Reduction in Hours of Employment <input type="checkbox"/> Divorce or Legal Separation <input type="checkbox"/> Loss of Dependent Child Status			
Reason for Enrollment: (check appropriate box)			
<input type="checkbox"/> New Hire	<input type="checkbox"/> Add / Delete Dependents	<input type="checkbox"/> Name Change / Address Change / PCP or NP Change	
<input type="checkbox"/> Loss of Other Coverage*	<input type="checkbox"/> Part-Time to Full-Time Employment (date of change: ____/____/____)	<input type="checkbox"/> Transfer to Retiree Segment	
<input type="checkbox"/> Open Enrollment	<input type="checkbox"/> COBRA / State Continuation	<input type="checkbox"/> Transfer to Disability Segment	
<input type="checkbox"/> Marriage	<input type="checkbox"/> Rehire (date: ____/____/____)	<input type="checkbox"/> Other	
<input type="checkbox"/> Birth, Adoption / Placement for Adoption	<input type="checkbox"/> Return from layoff (date: ____/____/____)		
*For loss of other coverage, please complete:			
Insurance Company _____		Phone # _____	
Subscriber # _____		Termination Date ____/____/____	
Coverage Type: <input type="checkbox"/> Employee <input type="checkbox"/> Employee / Spouse <input type="checkbox"/> Employee / Child(ren) <input type="checkbox"/> Family			

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	Date of Birth ____/____/____	Gender <input type="checkbox"/> M <input type="checkbox"/> F
Primary Care Physician (PCP) and Clinic: <small> Confirm your NP can be selected as a PCP at QuartzBenefits.com/findadoctor. If no PCP or NP preference, indicate "ASSIGN".</small>		Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
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	Date of Birth ____/____/____	Gender <input type="checkbox"/> M <input type="checkbox"/> F
Primary Care Physician (PCP) and Clinic: <small> Confirm your NP can be selected as a PCP at QuartzBenefits.com/findadoctor. If no PCP or NP preference, indicate "ASSIGN".</small>		Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
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	Date of Birth ____/____/____	Gender <input type="checkbox"/> M <input type="checkbox"/> F
Primary Care Physician (PCP) and Clinic: <small> Confirm your NP can be selected as a PCP at QuartzBenefits.com/findadoctor. If no PCP or NP preference, indicate "ASSIGN".</small>		Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
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	Date of Birth ____/____/____	Gender <input type="checkbox"/> M <input type="checkbox"/> F
Primary Care Physician (PCP) and Clinic: <small> Confirm your NP can be selected as a PCP at QuartzBenefits.com/findadoctor. If no PCP or NP preference, indicate "ASSIGN".</small>		Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
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	Date of Birth ____/____/____	Gender <input type="checkbox"/> M <input type="checkbox"/> F
Primary Care Physician (PCP) and Clinic: <small> Confirm your NP can be selected as a PCP at QuartzBenefits.com/findadoctor. If no PCP or NP preference, indicate "ASSIGN".</small>		Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No

IV. OTHER INSURANCE INFORMATION:

Will you or any of your dependents continue to have other insurance after the Quartz effective date of this policy? If Yes, complete -

Names of those covered under policy	Employer	
Insurance Company	Subscriber #	Group #
Effective Date of Coverage	Insurance Company Phone #	
Termination Date		
Are you or your spouse or child(ren) covered by Medicare (Parts A, B, C, or D)? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list name(s):		
Reason for Medicare: <input type="checkbox"/> Age 65 <input type="checkbox"/> Disability <input type="checkbox"/> End Stage Renal Disease <input type="checkbox"/> Disability and ESRD		
Part A Effective Date: ____/____/____		Part B Effective Date: ____/____/____
Part C Effective Date: ____/____/____		Part D Effective Date: ____/____/____
Are you or any dependents listed above involved in a Workers Compensation case? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, indicate who is involved and start date / accident date:		
Workers Compensation Condition:		
Insurance Company Name:		
Insurance Company Address (where claim is sent):		
Insurance Company Phone Group #	Effective Date: Term Date (if applicable):	

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 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.: _____

- I would have to pay more than 10 percent of my annualized gross income towards health insurance

- 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 considered Late Applicants subject to either a 12 month delayed effective date, or, if my employer has an Open Enrollment Period, may be able to apply for coverage at Open Enrollment.

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) 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, 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, birth, adoption or placement for adoption.

Non-Discrimination & Language Access

Quartz is the brand name for a group of companies committed to your health: Unity Health Plans Insurance Corporation, Physicians Plus Insurance Corporation, Gundersen Health Plan, Inc., and Gundersen Health Plan Minnesota. 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 Service 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, sex, gender identity, sexual orientation or health status.

We provide free aids and services to people with disabilities to communicate effectively with us, 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 interpreter
- Information written in other languages

If you need these services, contact Customer Service at (800) 362-3310.

For help to translate or understand this, please call (800) 362-3310, TTY / TDD: 711 / (800) 877-8973.

Spanish – Este aviso contiene información importante. Este aviso contiene información importante acerca de su solicitud o cobertura a través de Quartz. Preste atención a las fechas clave que contiene este aviso. Es posible que deba tomar alguna medida antes de determinadas fechas para mantener su cobertura médica u obtener ayuda con los costos. Usted tiene derecho a recibir esta información y ayuda en su idioma sin costo alguno. Llame al (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

Hmong – Tsab ntawv tshaj xo no muaj cov ntshiab lus tseem ceeb. Tsab ntawv tshaj xo no muaj cov ntsiab lus tseem ceeb txog koj daim ntawv thov kev pab los yog cov kev pab kam them nqi kho mob los ntawm Quartz. Saib cov caij nyoog ceeb hauv daim ntawv no. Tej zaum koj kuj yuav tau ua qee yam kom tsis pub dhau cov caij nyoog koj thiab yuav tau txais kev pab kam them nqi kho mob los yog kev pab them tej nqi kho mob. Koj muaj cai tau cov ntshiab lus no thiab tau kev pab ua koj hom lus pub dawb rau koj. Hu rau (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

Vietnamese – Thông báo này cung cấp thông tin quan trọng. Thông báo này có thông tin quan trọng bản về đơn nộp hoặc hợp đồng bảo hiểm qua chương trình Quartz. Xin xem ngày then chốt trong thông báo này. Quý vị có thể phải thực hiện theo thông báo đúng trong thời hạn để duy trì bảo hiểm sức khỏe hoặc được trợ giúp thêm về chi phí. Quý vị có quyền được biết thông tin này và được trợ giúp bằng ngôn ngữ của mình miễn phí. Xin gọi số (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

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 –

Kristie Meier, Compliance Officer
840 Carolina Street
Sauk City, WI 53583
Phone: (800) 362-3310
TTY / TDD: 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, Kristie Meier, 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.

Chinese – 本通知含有重要的訊息。本通知包含了關於您通過 Quartz 提交之申請或保險責任範圍的重要訊息。請留意本通知內的重要日期。您可能需要在若幹截止日期之前採取行動，以維持您的健康保險責任範圍或者費用補貼。您有權利免費獲得以您母語撰寫的本訊息和各種幫助。請致電 (800) 362-3310。聾啞人電話：711 / (800) 877-8973。

Russian – Настоящее уведомление содержит важную информацию. Это уведомление содержит важную информацию о вашем заявлении или страховом покрытии через Quartz. Посмотрите на ключевые даты в настоящем уведомлении. Вам, возможно, потребуется принять меры к определенным предельным срокам для сохранения страхового покрытия или помощи с расходами. Вы имеете право на бесплатное получение этой информации и помощь на вашем языке. Звоните по телефону (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

Laotian – ແຈ້ງການນີ້ມີຂໍ້ມູນສໍາຄັນ. ແຈ້ງການນີ້ມີຂໍ້ມູນທີ່ສໍາຄັນກ່ຽວກັບການສະໜັບສະໜູນ ທີ່ ການຄຸມຄອງຂອງທ່ານ ໂດຍຜ່ານ Quartz. ໃຫ້ເບິ່ງກຳນົດວັນທີ່ສໍາຄັນຢູ່ໃນແຈ້ງການນີ້. ທ່ານອາດຈະຕ້ອງໄດ້ໃຊ້ເວລາດູ່າເນີນການຕາມກຳນົດເວລາທີ່ແນະນຳ ເພື່ອຮັກສາການຄຸມຄອງຂອງທ່ານ ທີ່ການຊ່ວຍເຫຼືອທີ່ມີຄ່າໃຊ້ຈ່າຍ. ທ່ານມີສິດໄດ້ຮັບຂໍ້ມູນຂ່າວສານ ແລະ ການຊ່ວຍເຫຼືອເປັນພາສາຂອງທ່ານ ໂດຍບໍ່ເສຍຄ່າໃຊ້ຈ່າຍໃດໆ. ໃຫ້ໂທຫາເບີ (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

