2022 Individual Insurance Election Form

In order to enroll in Quartz individual insurance coverage, you will need to complete the Applicant Information and the Individual Insurance Election Form

Offered by:
Quartz Health Benefit Plans Corporation

840 Carolina Street • Sauk City, WI 53583-1374
(800) 362-3310 • (608) 644-3430
Fax (608) 643-2564 • **QuartzBenefits.com**

Requested Coverage Effective Date _____/_____/2022

1. Plan Options: (Please select a Network, Plan Type, and Dental Option)

NETWORK: ☐ Quartz One ☐ Beloit One

PLAN NAME	PLAN TYPE			
	Gold	**Silver**	**Bronze**	**Catastrophic**
	☐ Gold I401	☐ Silver I301	☐ Bronze I201	☐ Catastrophic I101*
	☐ Gold I402 Maintenance	☐ Silver I302	☐ Bronze I202	
	☐ Gold I403 HSA*	☐ Silver I303	☐ Bronze I203 HSA*	*Only individuals under 30 years old or with a hardship exemption qualify for Catastrophic Plans.*
	☐ Gold I405	☐ Silver I304 HSA*	☐ Bronze I204	

** The family dental option is not available.*

NETWORK: ☐ Tiered Choice Plus

PLAN NAME	PLAN TYPE	
	Gold	**Silver**
	☐ Gold I406	☐ Silver I305
	☐ Gold I407 Maintenance	☐ Silver I306
	☐ Gold I408 HSA*	
	☐ Gold I409	

** The family dental option is not available.*

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

DENTAL OPTION	
☐ No – *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 the Federally Facilitated Exchange 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.*	☐ Yes - I'd like to elect dental coverage for all members of my policy.

For plan descriptions, please visit QuartzBenefits.com or call Quartz Customer Service at (800) 362-3310.

Continue to the next page. →

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

	Name (First, MI, Last)	Primary Care Clinic	Are You A Current Patient?
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

☐ 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): _____

5. Invoice and Payment Options

Applicants will receive a mailed paper invoice unless applicant is a Quartz MyChart user. If you prefer to opt out of paperless invoicing, please review your preferences in MyChart by visiting QuartzMyChart.com. You can also arrange one-time or recurring Automated Clearing House (ACH) payments through MyChart. Other acceptable methods of payment include paper checks, cashier's checks, money orders, ACH, credit cards, and all general-purpose pre-paid debit cards.

Applicant's Full Name (Please print): _____ Date: _____

Applicant's Signature: _____

Continue to the next page. →

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:	20. Date of Birth (mm/dd/yyyy):
_____ – _____ – _____	☐ Male ☐ Female	_____/_____/_____

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 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

Continue to the next page. →

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. Date of Birth (mm/dd/yyyy):

_____/_____/_____

5. Sex:

☐ Male ☐ Female

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

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

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. Date of Birth (mm/dd/yyyy):

_____/_____/_____

5. Sex:

☐ Male ☐ Female

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.

Continue to the next page. →

10. Language for Person 3. Preferred spoken and written. Please check one:

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

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
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Pacific Islander
- ☐ White
- ☐ Declines to answer
- ☐ Unavailable

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. Date of Birth (mm/dd/yyyy):

_____/_____/_____

5. Sex:

☐ Male ☐ Female

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

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
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Pacific Islander
- ☐ White
- ☐ Declines to answer
- ☐ Unavailable

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

Continue to the next page. →

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. 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 within the first 24 months from the date of the policy or certificate 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.

I understand that I must pay all outstanding amounts owed for premiums to Quartz for the last 12 months in order for coverage to become effective.

Signature: _____ Date Signed: _____

STEP 4: Mail or email your completed application.

Mail your completed application to:
Quartz - Sales Department
840 Carolina Street
Sauk City, WI 53583

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

Continue to the next page. →

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.

Continue to the next page. →

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:	
4. 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.

Quartz

Non-Discrimination & Language Access

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 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, or sex.

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.

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: 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.

For help to translate or understand this, please call (800) 362-3310, TTY: 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 o 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 koj qhov kev pab cuam los ntawm Quartz. Saib cov caij nyoog los yog tej hnub tseem ceeb uas sau rau hauv daim ntawv no kom zoo. Tej zaum koj kuj yuav tau ua qee yam uas peb kom koj ua tsis pub dhau cov caij nyoog uas teev tseg rau hauv daim ntawv no mas koj thiaj yuav tau txais kev pab cuam kho mob los yog kev pab them tej nqi kho mob ntawd. Koj muaj cai kom lawv muab cov ntshiab lus no uas tau muab sau 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 bàn 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 trúp 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.

Chinese – 本通知含有重要的訊息 本通知對於您透過 Quartz 所提 出的申請或保險有重要的訊息 請在本通知中查看重要的日期 您可能要在特定的截止日期之 前採取行動，以保留您的健康保險或有助於省錢 您有權利免費以您的母語得到幫助和訊息 請致電 (800) 362-3310：711 / (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 – ແຈ້ງການສະບັບນີ້ມີຂໍ້ມູນທີ່ສຳຄັນ.
ແຈ້ງການສະບັບນີ້ມີຂໍ້ມູນທີ່ສຳຄັນກ່ຽວກັບໃບສະໝັກ ຫຼື ການຄຸ້ມຄອງຂອງທ່ານຜ່ານ Quartz. ຊອກຫາວັນທີສຳຄັນ ໃນຫນັງສືແຈ້ງການສະບັບນີ້.ທ່ານອາດຈຳເປັນຕ້ອງປະຕິບັດຕາມເວລາ ທີ່ກຳນົດໄວ້ທີ່ແນ່ນອນເພື່ອຮັກສາໄວ້ການຄຸ້ມຄອງສຸຂະພາບຂອງທ່ານ ຫຼື ຊ່ວຍເຫຼືອດ້ານຄ່າໃຊ້ຈ່າຍ.ທ່ານມີສິດທີ່ຈະໄດ້ຮັບຂໍ້ມູນນີ້ ແລະ ຄວາມຊ່ວຍເຫຼືອໃນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ. ໂທຫາເບີ (800) 362 3310. TTY / TDD: 711 / (800) 877 8973.

German – Diese Benachrichtigung enthält wichtige Informationen. Diese Benachrichtigung enthält wichtige Informationen bezüglich Ihres Antrags auf Krankenversicherungsschutz durch Quartz. Suchen Sie nach wichtigen Terminen in dieser Benachrichtigung. Sie könnten bis zu bestimmten Stichtagen handeln müssen, um Ihren Krankenversicherungsschutz oder Hilfe mit den Kosten zu behalten. Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Rufen Sie an unter (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

Arabic – يحتوي هذا الإشعار على معلومات مهمة. يتضمن هذا الإشعار معلومات هامة حول طلبك أو تغطيتك عبر Quartz. ابحث عن التواريخ الرئيسية في هذا الإشعار. قد تحتاج إلى إجراء تدابير معيّنة وفقاً لمواعيد معيّنة من أجل الحفاظ على تغطيتك الصحية أو المساعدة في التكاليف. ليدك الحق في الحصول على هذه المعلومات وعلى المساعدة في لغتك دون أي تكلفة. اتصل على TTY / TDD: 711 / (800) 877-8973 / (800) 362-3310.

French – Cet avis a d'importantes informations. Cet avis a d'importantes informations sur votre demande ou la couverture par l'intermédiaire de Quartz. Rechercher les dates clés dans le présent avis. Vous devrez peut-être prendre des mesures par certains délais pour maintenir votre couverture de santé ou d'aide avec les coûts. Vous avez le droit d'obtenir cette information et de l'aide dans votre langue à aucun coût. Appelez (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

Korean – 본 통지서에는 중요한 정보가 들어 있습니다. 즉 이 통지서는 귀하의 신청에 관하여 그리고 Quartz을 통한 커버리지 에 관한 정보를 포함하고 있습니다.본 통지서에서 핵심이 되는 날짜들을 찾으십시오. 귀하는 귀하의 건강 커버리지를 계속유지하거나 비용을 절감하기 위해서 일정한 마감일까지 조치를 취해야 할 필요가 있을 수있습니다. 귀하는 이러한 정보와 도움을 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가있습니다. (800) 362-3310 로 전화하십시오. TTY / TDD: 711 / (800) 877-8973.

Tagalog – Ang Paunawa na ito ay naglalaman ng mahalagang impormasyon. Ang paunawa na ito ay naglalaman ng mahalagang impormasyon tungkol sa iyong aplikasyon o pagsakop sa pamamagitan ng Quartz. Tingnan ang mga mahalagang petsa dito sa paunawa. Maaring mangailangan ka na magsagawa ng hakbang sa ilang mga itinakdang panahon upang mapanatili ang iyong pagsakop sa kalusugan o tulong na walang gastos. May karapatan ka na makakuha ng ganitong impormasyon at tulong sa iyong wika ng walang gastos. Tumawag sa (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

Pennsylvanian Dutch – Die Bekanntmaching gebt wichdichi Auskunft. Die Bekanntmaching gebt wichdichi Auskunft baut dei Application oder Coverage mit Quartz. Geb Acht fer wichdiche Daadem in die Bekanntmachung. Es iss meeglich, ass du ebbes duh muscht, an beschtimmde Deadlines, so ass du dei Health Coverage bhalde kannscht, odder bezaahle helfe kannscht. Du hoscht es Recht fer die Information un Hilf in deinre eegne Schprooch griege, un die Hilf koschtet nix. Kannscht du (800) 362-3310 uffrufe. TTY / TDD: 711 / (800) 877-8973.

Polish – To ogłoszenie zawiera ważne informacje. To ogłoszenie zawiera ważne informacje odnośnie Państwa wniosku lub zakresu świadczeń poprzez Quartz.Prosimy zwrócic uwagę na kluczowe daty zawarte w tym ogłoszeniu aby nie przekroczyć terminów w przypadku utrzymania polisy ubezpieczeniowej lub pomocy związanej z kosztami. Macie Państwo prawo do bezpłatnej informacji we własnym języku. Zadzwońcie pod (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

Hindi – **इस सूचना में महत्वपूर्ण जानकारी शामिल है।** इस सूचना में Quartz से जुड़े आपके आवेदन या कवरेज के बारे में महत्वपूर्ण जानकारी शामिल है। इस सूचना में महत्वपूर्ण तारीखों को देखना न भूलें। स्वास्थ्य कवरेज जारी रखने या खर्चे में मदद के लिए आपको कुछ तय तारीखों तक कार्रवाई करनी ज़रूरी है। आपके पास अपनी भाषा में, बिना किसी शुल्क के इस जानकारी और सहायता को पाने का अधिकार है। (800) 362-3310. TTY / TDD: 711 / (800) 877-8973 पर कॉल करें।

Albanian – Ky njoftim përmban informacion të rëndësishëm. Ky njoftim përmban informacion të rëndësishëm për aplikimin ose mbulimin tuaj nëpërmjet Quartz. Kontrolloni për data të rëndësishme në këtë njoftim. Mund t'ju duhet të ndërmerrni veprim brenda afatave të caktuara për të mbajtur mbulimin tuaj shëndetësor ose për ndihmën me koston. Keni të drejtë ta merrni këtë informacion dhe ndihmë falas në gjuhën tuaj. Telefononi numrin (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

Somali – FIIRO GAAR AH: Haddii aad ku hadashid af Soomaali, adeegyada caawimada luuqada, ayaa waxaa laguugu siinayaa bilaash, waa laguu heli karaa. 1-800-362-3310 (TTY: 1-800-877-8973) bilbilaa.

Cushite – Oroomiffa XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

Amharic – ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ (800) 362-3310. (መስማት ለተሳናቸው: 711 / (800) 877-8973).

Karen – ဟ်သူဉ်ဟ်သး– နမ့်ကတိၤ ကညီ ကျိာ်ဏယိ, နမၤန့်ါ ကျိာ်ဏတ်မၤစၢၤလၢ တလၫ်ဘူဉ်လၫ်စ့ၤ နီတမံၤဘဉ်သ့နှဉ်လီၤ. ကိး (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

Mon-Khmer, Cambodian – ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

Serbocroatian – OBAVJEŠTENJE: Ako govorite srpskohrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite (800) 362-3310 TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711 / (800) 877-8973.

Thai – เรียน: ถา้ คุณพดู ภาษาไทยคุณสามารถใชบ้ ริการช่วยเหลือทางภาษาไดฟ้ รี โทร (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

Gujarati – સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

Urdu – خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

Italian – ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

Greek – ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.