New York Small Group Business
Employer Application

FOR GROUP COVERAGE (2–50 ELIGIBLE EMPLOYEES)

Life, Accidental Death & Dismemberment, and Aetna Managed Choice Plan PPO are provided by Aetna Life Insurance Company. Aetna Primary Care Plan HMO and Aetna QPOS are provided by Aetna Health Inc. DMO and PPO dental plans are provided by Aetna Life Insurance Company except Dental HMO Rider coverage which is provided by Aetna Health Inc.

Company Name (Legal Name)	DBA/Doing Business As (if applicable)		
Street Address (P.O. Box not acceptable)	City	State	Zip
Billing Address (If different than above)	City	State	Zip
Company Contact Person - Title	Phone Number ( )	Fax Number ( )	
E-Mail Address	Federal Tax ID Number	Date Business Established (Mo/Yr):	

Employer Classification ☐ Corporation ☐ Non-Profit ☐ Partnership ☐ Sole Proprietor ☐ Other: _____

SIC Code: _____ Nature of Business: _____

Medical Coverage Selection

- ☐ **HMO Open Access – 20** (Available in Metro NY **only**)
- ☐ **POS Open Access – 20**
- ☐ **POS Open Access – 21**
- ☐ **POS Open Access – 22**
- ☐ **Managed Choice Open Access – 21**
- ☐ **Managed Choice Open Access – 22**
- ☐ **Managed Choice First Dollar – 23**
- ☐ **Managed Choice Open Access (please check one):**
  ☐ 24 ☐ 25 ☐ 26 ☐ 27 ☐ 28 ☐ 29
- ☐ **EPO Open Access (please check one):**
  ☐ 1 ☐ 2
- ☐ **Indemnity – 20**

Dental Coverage Selection

Aetna Dental™ Plan

☐ Plan Option 1 ☐ Plan Option 2 ☐ Plan Option 3
☐ Plan Option 4 ☐ Plan Option 5 ☐ Plan Option 6

Orthodontia coverage is included only in Plan Options 2, 3, 5 & 6 and only to groups with 10 or more eligible employees.

Life, Accidental Death & Dismemberment, & Disability Coverage Selections

Groups with 10 to 50 eligible employees may select one, two or three options for Life, Accidental Death & Dismemberment and Disability. If more than one option is selected, describe each class of employees, indicate the amount selected for each class and attach a list of employee names with each class designation. (Limited to 3 classes. The highest option selected can be no more than 5 times the lowest option.)

	Class 1 Life	Class 2 Life	Class 3 Life
All Groups	☐ $10,000 ☐ $15,000 ☐ $20,000 ☐ $50,000	☐ $10,000 ☐ $15,000 ☐ $20,000 ☐ $50,000	☐ $10,000 ☐ $15,000 ☐ $20,000 ☐ $50,000
Additional options for Groups with 10 – 50 eligible employees	☐ $75,000 ☐ $100,000 ☐ $125,000	☐ $75,000 ☐ $100,000 ☐ $125,000	☐ $75,000 ☐ $100,000 ☐ $125,000
Class Description			

Optional Dependent Term Life (Available only to groups with 10 to 50 eligible employees.) ☐ Yes ☐ No

Effective Date Actual effective date will be assigned by the Aetna underwriting department if application is approved.

Requested effective date (may be the first or 15th of the month only): _____

Employer Contribution(s)

	Employer's Contribution for Employee Coverage % Contribution	Employer's Contribution for Dependent Coverage % Contribution
Medical	_____%	_____%
Dental	_____%	_____%
Basic Employee Term Life (including AD&D)	_____%	N/A
Optional Dependent Term Life	N/A	_____%

Employee Eligibility

Work Location (list by state)	Number of Employees				
	Full-time (based on number of minimum hours allowed by state law)	Part-time	Retired	COBRA or State Continuees	Other (i.e., temporary, substitute, seasonal)

Total number of employees: _____

Is your group subject to COBRA? (20 or more total employees during at least 50% of the working days in the previous calendar year):
☐ Yes ☐ No

Total number of employees eligible for coverage (must work a minimum of 20 hours per week): _____

Total number of employees waiving Aetna health benefits but covered through their spouse's health benefit plan: _____

Total number of employees waiving Aetna health benefits coverage without coverage elsewhere: _____

Total number of employees covered under another health benefit plan offered by the employer: _____

Do you exclude Union employees under this application? ☐ Yes ☐ No

Eligibility date will be the first day of the policy month following the waiting period.

Waiting period for future employees: ☐ 0 days ☐ 30 days ☐ 60 days ☐ 90 days ☐ 120 days ☐ 180 days

Prior Carrier Information

Health:

Will coverage be transferring from another carrier: ☐ Yes ☐ No

If yes, name of the carrier: _____ Proposed Termination Date: _____

If prior carrier is Aetna, provide group or control #: _____ Total Replacement: ☐ Yes ☐ No

Has the group been uninsured for three or more months prior to the requested effective date: ☐ Yes ☐ No

Dental:

Will coverage be transferring from another carrier: ☐ Yes ☐ No

If yes, name of the carrier: _____ Proposed Termination Date: _____

If prior carrier is Aetna, provide group or control #: _____ Total Replacement: ☐ Yes ☐ No

Prior Coverage included coverage for (check all that apply) ☐ Major Services ☐ Orthodontia

Has the group been uninsured for three or more months prior to the requested effective date: ☐ Yes ☐ No

Life and AD&D:

Will coverage be transferring from another carrier: ☐ Yes ☐ No

If yes, name of the carrier: _____ Proposed Termination Date: _____

If prior carrier is Aetna, provide group or control #: _____ Total Replacement: ☐ Yes ☐ No

Signature Section

The Applicant agrees that at no time shall any employee be permitted or required to contribute for non-contributory coverage; or, unless the change is approved in writing by an authorized representative of Aetna, to make contributions for contributory coverage at a rate higher than the initial contribution rate applicable for the employee's then current coverage. It is agreed that no coverage shall become effective as to any person who is not then a bona fide, full-time employee, regularly performing the duties of his or her occupation (subject to applicable HIPAA requirements for health coverage), unless otherwise specifically provided in the plan documents (which consist of the Group Agreement and/or Group Policy). All statements herein shall be deemed representations and not warranties.

The Applicant acknowledges that it has selected this plan based upon written information provided by Aetna and that no broker, agent or consultant is authorized to modify the terms of the offer or to agree to changes. All material terms of plan coverage are set forth in the plan documents. Applicant agrees to make payroll and other records directly related to employee's coverage under the Group Agreement or Group Policy available to Aetna for inspection, at Aetna's expense, at Applicant's office, during regular business hours, upon reasonable advance request. This provision shall survive termination of the Group Agreement or Group Policy.

Applicant has selected, in accordance with applicable state law, the plan to be offered to Applicant's employees and Applicant has solely determined any/all health plan options for the Applicant's employees and the contribution amounts.

In accordance with current IRS regulations and the 1986 Tax Reform Act, a life insurance position schedule may be deemed discriminatory and result in imputed income tax to certain employees and possibly an excise tax to employers. Employers should consult with legal counsel prior to electing a position schedule. Aetna disclaims any responsibility if the employer elects such a position schedule and it is later deemed discriminatory.

The plan documents will determine the contractual provisions, including procedures, exclusions and limitations relating to the plan and will govern in the event they conflict with any benefits comparison, summary or other description of the plan.

With the exception of Aetna Rx Home Delivery, participating physicians, hospitals and other health care providers are independent contractors and are neither agents nor employees of Aetna. Aetna Rx Home Delivery, LLC, is a subsidiary of Aetna Inc.

Applicant agrees to deliver, or otherwise make available to enrollees, all Aetna paper or online member documents and other plan-related materials upon request by Aetna.

As to Accident and Health Insurance coverage, any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

All data that may have a bearing on coverage or premiums will be open for Aetna to inspect while the Group Agreement or Group Policy is in force.

The availability of a plan or program may vary by geographic service area. Some benefits are subject to limitations or maximums. Aetna does not provide health or dental care services and, therefore, cannot guarantee any results or outcome.

I hereby apply for the coverage(s) indicated above. I certify that all information provided in this application is accurate and complete.

I understand that this application will form a part of the Group Agreement or Group Policy issued by Aetna, and by my signature below I agree to be bound by the terms and conditions of that Group Agreement or Group Policy. I understand that Aetna may choose not to accept this application at its sole discretion, subject to any state requirements.

Signed at (Location): _____ _____
City, State — Applicant (Company Name)

By: _____ _____
Authorized Applicant Signature — Official Title

_____ _____
Witness — Date

Agent/Broker Certification

I hereby certify that I am not aware of any information not disclosed in this application by the client which may have bearing on this risk, including my knowledge that replacement life insurance is ☐ is not ☐ (check one) a part of this transaction.

I hereby certify that I am licensed to sell Aetna Small Group products in the state of New York.

I hereby certify that I have advised the client not to terminate any existing coverage until receiving written notice from Aetna that the coverage being applied for by this application is accepted.

Agent/Broker Name: _____ Aetna Agent Number/Tax ID/SSN: _____

Agency Name: _____ % of Credit: _____

Phone Number: (____) _____ Fax Number: (____) _____

Address: _____ City: _____ State: _____ Zip: _____

Signature: _____ Date: _____ E-Mail Address: _____

Agent/Broker Name: _____ Aetna Agent Number/Tax ID/SSN: _____

Agency Name: _____ % of Credit: _____

Phone Number: (____) _____ Fax Number: (____) _____

Address: _____ City: _____ State: _____ Zip: _____

Signature: _____ Date: _____ E-Mail Address: _____

General Agent Name: _____ Aetna Agent Number/ID Number: _____

Phone Number: (____) _____ Fax Number: (____) _____

Address: _____ City: _____ State: _____ Zip: _____

Signature: _____ Date: _____ E-Mail Address: _____

For Aetna Use Only

Group Number _____ Control Number _____ SCD _____ Effective Date _____

Is Agent/Agency licensed and appointed? ☐ Yes ☐ No Appointment Expiration Date _____