NEW JERSEY EMPLOYER APPLICATION

(51 – 100 Eligible Employees)

Life, Accidental Death & Personal Loss, Disability, Aetna Managed Choice and Aetna Indemnity plans are underwritten by Aetna Life Insurance Company. The In-network component of our Savings Plus Health Network Option plans are underwritten by Aetna Health Inc. The Out-of-Network component of our Savings Plus Health Network Option plans is underwritten by Aetna Health Insurance Company. DMO and Voluntary DMO coverage is underwritten by Aetna Dental Inc. Aetna Life Insurance Company provides all other dental coverage.

Please Print or Type	For Aetna Use Only
☐ New Policy ☐ Change in Policy Requested Effective Date ______________ **NOTE:** The Effective Date will be on or after the date Aetna approves the application.	Policy Number ______________

Section I: POLICYHOLDER INFORMATION

1. Policyholder (Full Legal Name of Company)
2. Tax Identification Number
3. Main Address: Street | City | State | ZIP

   Mailing Address: Street | City | State | ZIP

   Telephone Number ( ) | Facsimile Number ( )

Are there additional addresses/locations for this business? ☐ Yes ☐ No If yes, provide all locations and addresses.

4. Company Contact Name and Title | Company Contact E-mail Address
5. Billing Contact Name (if different from Company Contact) | Billing Contact E-mail Address
6. Enrollment Contact Name (if different from Company Contact) | Enrollment Contact E-mail Address

   Go green – online statements available. Activate access to your eBusiness account at www.aetna.com/emplooyersregister upon receipt of your approval letter.
7. Type of Organization

   ☐ Corporation ☐ Non-Profit ☐ Partnership ☐ Proprietorship ☐ LLC ☐ LLP ☐ Other (explain):
8. Nature of Business (specify) | SIC Code
9. Number of eligible employees in your company
10. Number of eligible employees to be covered | Class or classes to be excluded
11. Coverage requested for ☐ Employees Only ☐ Employees and Dependents

    The term "spouse" shall include a Civil Union partner as defined by New Jersey State Law. In addition, a same sex relationship entered into outside of New Jersey which is valid under the law of another state or foreign nation that provides substantially all of the rights and benefits of marriage, shall be valid in New Jersey. If dependent children are covered under this plan, a dependent child of a civil union partner is eligible for coverage.
12. Waiting period before employees become covered (may not exceed 90 days):

    Current Employees: ______________ New or Rehired Employees: ______________

    The eligibility date will be the first day of the policy month following the waiting period, except 90 days exact. Policy month refers to the contract effective date of the 1st or 15th. If "0" days is selected and the employee is hired on the 1st of the month, the effective date will be the date of hire. If "Exactly 90 Days" is selected the enrollment eligibility date will begin 90 calendar days following the date of hire.
13. **Employer Contribution(s)**

Coverage	Medical	Dental	Employee Life	Dependent Life	Life/Disability
Employer Contribution for Employee	%	%	%	N/A	%
Employer Contribution for Dependent	%	%	N/A	%	N/A

14. Employee Disability Contribution

    Check one: ☐ Pre-Tax ☐ Post-Tax

continued on next page

Section I: POLICYHOLDER INFORMATION *(continued)*

15. Is the Employer or Third Party funding or administering any part of the deductible, coinsurance, and/or copayment now, or plan to do so in the next 12 months? ☐ Yes ☐ No If "Yes," who is administering the funding:
    Employer/Third Party Administrator (Indicate name: ______________________________)
    What percentage/amount of the deductible is being funded? (The employer may only fund a maximum of up to 50% of the deductible.) ______________

16. **Early Retirees:** Are they offered the same benefits as full-time? ☐ Yes ☐ No
    How many are younger than age 65? __________ How many are older than age 65? __________

17. Deposit
    $ ____________________ Premium Paid: Monthly
    Premium will be due as of the effective date.
    The premium for the first month of coverage must be attached.

18. **Affiliates, subsidiaries or branches (must be included for the purposes of participation)**

Business Name	Tax Identification Number	Owner's Name	Ownership Percentage	Number of Employees	Is group to be included?
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No

Section II: SPECIFICATIONS FOR COVERAGE

Health Benefits:

☐ NJ Savings Plus Health Network Option – Plan Option: ______________________________
☐ NJ Managed Choice (MC) – Plan Option ______________________________
☐ NJ Open Access® Managed Choice (OA MC) – Plan Option ______________________________
☐ NJ Open Access® Managed Choice (OA MC) HSA Compatible – Plan Option ______________________________
Plan Administration: ☐ Calendar Year ☐ Plan Year
☐ NJ Indemnity

Dental Benefits:

☐ Standard Plans: Option Number ____________________ Plan Option Name ____________________
☐ Voluntary Plans: Option Number ____________________ Plan Option Name ____________________

Orthodontic coverage for dependent children may be included for groups with 10 or more eligible employees.

For groups with less than 25 employees, DMO® can be sold standalone, packaged with PPO, or offered as part of the Freedom-of-Choice plan design options.

For groups with 25 or more employees, DMO® must be packaged with one of the PPO options or offered as part of the Freedom-of-Choice plan design options.

The Consumer Directed DentalFund and Aetna Dental Preventive Care℠ cannot be sold with any other dental option.

Life and Disability Benefits:
Contact your Aetna Sales Executive.

Section III: ALL QUESTIONS MUST BE ANSWERED

1. Is there any Group Health Plan:
   - now in force and to be continued? ☐ Yes ☐ No
   - currently being applied for? ☐ Yes ☐ No

   If "Yes", identify the name of the Group Health Plan, give a description of the plan(s) and the name of carrier(s):
   ____

2. Name of present or prior group carrier ______________________________
   Effective date of prior coverage ____________________ Cancellation/Termination Date ____________________
   Is the coverage applied for in this application replacing other group coverage? ☐ Yes ☐ No
   If "Yes" give reason ______________________________
   Plan being replaced ☐ A ☐ B ☐ C ☐ D ☐ E ☐ HMO ☐ HMO/POS ☐ Dual Contract POS
   ☐ Other ______________________________
   Other Coverage Being Replaced: ☐ Dental ☐ Life ☐ Disability
3. Has your firm been without coverage for 3 or more months prior to application? ☐ Yes ☐ No
4. What forms of coverage are now or were in force? ☐ Health Benefits ☐ Prescription Drugs
   (Attach copies of Booklet/Certificate and most recent Billing Statement.)
5. Are extended benefits provided in case of termination of health benefits? ☐ Yes ☐ No

continued on next page

6. To the best of your knowledge, are there any current or former employees or their eligible dependents whose health coverage is being continued?
☐ Yes ☐ No
Please provide the following information for each current/former employee or dependent on health continuations.
If additional space is needed, attach a separate sheet, signed and dated.

Name of Employee/ Dependent	Date of Birth	Type of Continuation State/Federal/ Extended Benefits	Reason for Termination Disability/Other	Continuation Dates	
				Start	End

7. To the best of your knowledge:
   a. Are any employees or dependents presently incapacitated? ☐ Yes ☐ No
   b. Are any dependent children incapable of self-support due to a physical or mental disability? ☐ Yes ☐ No
   Additional space to explain if items 1, 2 or 3 were answered "Yes". Refer to the question number, and give details, including names, where appropriate.

8. Does the employer participate in an arrangement with a Professional Employer Organization? ☐ Yes ☐ No
(Refer to Advisory bulletin 00-SEH-02 if you need information concerning what constitutes a Professional Employer Organization.)
Please indicate below the number of employees by work location/state. All employees must be included, regardless of whether or not they currently have medical coverage and through whom that coverage is provided.

Affiliated Companies

Is your company a subsidiary of another company, an affiliate of another company, or under common control with another company?	☐ Yes ☐ No
Does your company file state or federal taxes with another company(ies) on a combined or consolidated basis?	☐ Yes ☐ No
Are there any associated companies to be included with this group that are commonly owned?	☐ Yes ☐ No
Are multiple companies or multiple addresses to be included under this plan?	☐ Yes ☐ No

If "Yes" to any questions, complete and submit Aetna's Common Ownership form and provide a copy of the Quarterly Wage and Tax Statement for each group to be included for coverage.

Is your company a branch of another company, or does your company have branch offices?	☐ Yes ☐ No

Work Location/State	Number of Employees				
	Full-time	Part-time	Retired	COBRA or State Continuees	Other

An Eligible Employee is one who works on a full-time basis with a normal work week of 25 or more hours for compensation. An employee who works less than 25 hours per week or works on a temporary or substitute basis, or participates in an employee welfare arrangement established pursuant to a collective bargaining agreement is not an eligible employee

Total number of eligible employees waiving Medical/Dental/Life/Disability benefit coverage under the policy **with** coverage under their spouse's coverage or any other Life/Disability/Dental Benefits Plan offered by the employer:

Medical ____________ Dental ____________ Life ____________ Disability ____________

Total number of eligible employees waiving Life/Disability/Dental benefit coverage under the policy **without** coverage under a spouse's coverage or any other Life/Disability/Dental Benefits Plan offered by the employer:

Medical ____________ Dental ____________ Life ____________ Disability ____________

Total number of employees in an ineligible class or classes: ______________________________

Medicare Primary versus Secondary

Question	Response
Is your group Medicare Primary (employed less than 20 employees for 20 consecutive weeks in the current or prior year) or Aetna Primary (employed 20 or more employees for 20 consecutive weeks in the current or prior year)? *Include:* Full-time, Part-time, Seasonal, Temporary, Union, Owners, Partners, Officers *Exclude:* Self-employed persons, Independent contractors (1099), Directors, Leased employees	☐ Medicare Primary ☐ Aetna Primary
How many full-time and part-time employees have you employed for 20 or more weeks during this calendar year or prior calendar year?	
100 or More Employees – Disabled Provision: How many full-time and part-time employees did you employ on 50% or more of your business days during the prior calendar year?	

Affordable Care Act (ACA) Medical Loss Ratio Requirement

Question	Response
What is the average number of employees you employed for the entire previous calendar year regardless of whether or not they were eligible for coverage? An employee is defined as any person for whom the company issues a W-2, including full time, part-time, and seasonal workers, and regardless of insurance eligibility.	

Section IV: SIGNATURE

It is understood that except as provided under applicable regulations no individual shall become covered while not actively at work on a full time basis, and only full-time employees are eligible. A full-time employee is one who regularly works at least 25 hours per week at his employer's place of business.

It is further understood that no agent has power on behalf of Aetna Health Inc. and/or Aetna Health Insurance Company and/or Aetna Life Insurance Company and/or Aetna Dental Inc. to make or modify any request or application for coverage or to bind Aetna Health Inc. and/or Aetna Health Insurance Company and/or Aetna Life Insurance Company and/or Aetna Dental Inc. by making any promise or representation or by giving or receiving any information.

It is further understood that no coverage will be effective unless and until the application is accepted in writing by Aetna Health Inc. and/or Aetna Health Insurance Company and/or Aetna Life Insurance Company and/or Aetna Dental Inc. Final rates will be based on enrollment data as of the Policy effective date. No coverage is to be implied in any way on the basis of the completion and/or submission of this application.

Any person who includes any false or misleading information on an application for a policy is subject to criminal and civil penalties. I certify that all statements made on this application are true and complete to the best of my knowledge and belief.

New Jersey law requires that plan sponsors with 25 or more employees contributing to dental plan organization (DMO®) coverage also offer to covered persons the option of selecting alternative coverage which permits covered persons to obtain dental services from any licensed dentist.

State law also requires that Aetna Life Insurance Company and/or Aetna Dental Inc. provide affected plan sponsors with copies of the applicable statutes/regulations and that those plan sponsors furnish to us written verification of their compliance with the law.

Per your signature below, you certify your organization's receipt of and compliance with New Jersey Statutes 17:48D-9.1 and 9.2 and New Jersey Administrative Code 11:10-2.1 through 2.6 requiring selection of alternate coverage.

Employer Acknowledgment – Employer Waiting Period

Starting with plan years on or after 1/1/2014, the Affordable Care Act and subsequent federal regulations prohibit group health plans and health insurance issuers from requiring any otherwise eligible plan participants and beneficiaries (employees and dependents) to wait more than ninety (90) days before their health coverage is effective. The regulations define group health plan as the employer or plan administrator. The issuer is defined as the insurance company. Since the requirement applies to both the group health plan and the issuer, each party's obligation is satisfied if the ninety (90) day waiting period is honored. However, if neither party complies, both are subject to penalty.

The Employer Group Policyholder ("Employer") represents that it provides to Aetna, effective date information regarding plan participants and beneficiaries that takes into account the eligibility conditions and waiting period requirements required under federal law, in order for such plan participants and beneficiaries to become eligible for coverage under the Employer's group health insurance coverage with Aetna. In compliance with the waiting period requirements, Aetna shall use the effective date information provided by Employer to enroll such plan participants and beneficiaries in the Employer's group health insurance coverage. In the event this information changes, the Employer shall inform Aetna immediately.

ELECTRONIC ENROLLMENT, BILLING/PAYMENT AND ACCESS AGREEMENT

Enrollment: As part of your participation date, the following terms and conditions apply:

1. You agree to keep copies (paper or electronic) of actual enrollment forms and agree to maintain a reasonably complete record of enrollment and eligibility information (via electronic, interactive voice response technology and/or hard copy format), including evidence of coverage elections, evidence of eligibility, changes to such elections and terminations. Records must be available to Aetna upon request and retained for seven years.
2. For electronic enrollment submissions or changes you agree to create and maintain the records on secure information systems that can generate hard copy records of enrollments or changes entered or maintained on those information systems. Any hard copy records generated pursuant to this provision shall meet reasonable standards of availability, authenticity, non-repudiation and integrity.
3. You represent that all enrollment and eligibility information presented to Aetna is accurate and timely updated. You acknowledge that Aetna can and will rely on such enrollment and eligibility information in determining whether an individual is eligible for benefits under the plan. In the event of a discrepancy between enrollee information (including salary data) submitted and information actually presented by the enrollee on any particular claim for benefits, and the result is that Aetna must pay a higher benefit to reflect the actual information presented by the enrollee, you agree to pay promptly to Aetna applicable back premiums accruing as of the date on which the enrollee's information changed.
4. Insured plans must either (1) use Aetna-supplied forms in paper format or electronic format or (2) agree to incorporate the following four points into your enrollment materials.
   a. Names(s) of the Aetna company offering the insurance coverage
   b. State-specific fraud warning statement
   c. A statement that the terms of the insurance documents will govern the member's rights and responsibilities
   d. An acknowledgment that participating providers are not agents or employees of Aetna and that network composition can change.

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Section IV: SIGNATURE

5. You are responsible for adhering to both state and federal laws and regulations when submitting terminations to Aetna.
6. If otherwise permitted, when retro-terminations are submitted, we will regard the submission as verification that no premium/contribution was paid by the member/dependent for that period.

Billing/Payment: You agree to receive your bill online each month. Any contractual provisions related to non-payment of premium continue to be applicable. I/we understand and agree to the terms set forth in this Agreement. By signing below, I represent that I am authorized to sign this Agreement.

Access: Plan sponsor agrees that each employee will agree to terms associated with the issuance and use of his/her password and system access. An individual's password may be used only by that individual to access the system and may not be shared for any reason. Each individual is personally responsible for the information entered into the system. If an individual to whom a password has been issued becomes aware of a security breach (an incident in which there occurs attempted or unauthorized access, use, disclosure, modification, or destruction of information or interface with system operations), they agree to contact Aetna.

SUMMARY OF BENEFITS - PLEASE READ AND CHECK BELOW TO CONFIRM:

☐ In accordance with my contract with Aetna to distribute information related to enrollment/coverage information, I have received the Summary of Benefits and Coverage document associated with the plan information referenced in this application. I confirm I will provide SBCs to plan participants and beneficiaries in compliance with the federal regulation and guidance related to SBCs, including the requirements for timing and delivery.

Date at ______________________________ on ____________________

Print Name of Officer, Partner or Proprietor ______________________________

Signature of Officer, Partner or Proprietor ______________________________

Witness to Signature ______________________________

Note: If there are any modifications to the statements and answers given in this application (i.e., crossed out, whited-out, erased information), the applicant must attest to the modifications by giving a complete signature in the margin near the modification.

Section V: AGENT/PRODUCER INFORMATION

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, for all products being applied for including life insurance, if applicable. I hereby represent that I am licensed and appointed to sell Aetna Group products in the state of New Jersey. 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.

Information on agent's compensation is available from your agent or at Aetna.com.

Agent/Broker Name:				
National Producer Number:		SSN:		
Agency Name:		TIN:		
Pay commissions to (check one): ☐ Broker ☐ Agency		Phone:	Fax:	
Address:		City:	State:	ZIP:
Signature:	Date:	E-mail Address:		% of credit:
Broker Admin Assistant Name:		Broker Admin Assistant E-mail address:		

Agent/Broker Name:				
National Producer Number:		SSN:		
Agency Name:		TIN:		
Pay commissions to (check one): ☐ Broker ☐ Agency		Phone:	Fax:	
Address:		City:	State:	ZIP:
Signature:	Date:	E-mail Address:		% of credit:
Broker Admin Assistant Name:		Broker Admin Assistant E-mail address:		

General Agency Name:	E-mail Address:		
TIN:	Selling Agent Name:		
Phone:	Fax:		
Address:	City:	State:	ZIP:
GA Admin Assistant Name:	GA Admin Assistant E-mail address:		

New Jersey Administrative Code

11:10-2.1 Purpose

P.L. 1983, Chapters 142 through 145, require that each employer or other organization subject thereto offer its employees or members the option of selecting alternate coverage which permits covered persons to obtain dental services from any dentist of their choice whenever the employer is contributing to a dental plan contract (as described in N.J.A.C. 11:10-2.2(a)). These statutes also direct the Commissioner to promulgate rules and regulations to effectuate their purposes. This subchapter is being promulgated to meet this statutory mandate and to implement the notification requirements of the statutes.

11:10-2.2 Scope and Application

(a) This subchapter applies to each employer or other organization which:

1. Employs or has 25 or more employees or members during the full preceding calendar year; and,
2. Contributes to a dental plan contract.

(b) Insurers, dental plan organizations, and dental service corporations which are authorized to enter into contracts providing dental coverage are also subject to this subchapter.

11:10-2.3 Definitions

The following words and terms, when used in this subchapter, have the following meanings unless the context clearly indicates otherwise:

"Alternative coverage" means a plan that permits covered persons to obtain dental services from any licensed dentist.

"Dental plan contract" means any contract issued by a health insurer, dental plan organization, or dental service corporation which restricts covered persons in selecting the providers of dental services to a single provider or a limited number of providers.

"Enrollment period" means a period of time, of not less than one month's duration, prior to the renewal of a dental plan contract during which employees (Publication page references are not available for this document.) or members are afforded the option to be covered under the dental plan contract or alternative coverage.

"Other organization" means a group of 25 or more members to which a dental plan contract has been or is to be issued including, but not limited to, labor unions and associations.

"Renewal" means to begin a new term of the contract or to add an amendment to the contract.

11:10-2.4 Notification of affected parties

(a) An insurer, dental plan organization and dental service corporation shall provide to each employer or other organization to which this subchapter applies a copy of N.J.S.A. 17:48D-9.1 and 9.2 (as appropriate) and this subchapter at the time of offering a dental plan contract as defined in this subchapter.

(b) Every employer and other organization subject to this subchapter, shall offer in writing to its employees or members and their eligible dependents the option of selecting coverage which permits dental services to be obtained from any licensed dentist as an alternative to the coverage provided under a dental plan contract. For new dental plan contracts being provided for the first time, this option shall be offered during the period for enrolling the employees or members in the new plan. For existing dental plan contracts, this option shall be offered during an enrollment period preceding the renewal date of the contract. Employers and other organizations which have offered this option to existing employees or members shall also offer this option to new employees or members at the time they are enrolled in a dental plan contract.

(c) Employers and other organizations to which this subchapter applies, shall post in a conspicuous manner, written notice of the coverage option and the text of P.L. 1983, Chapters 142- 145, whichever chapter is applicable.

11:10-2.5 General rules

(a) Each health insurer, dental service corporation, or dental plan organization shall, at the time a dental plan contract is offered or at the time of renewal, obtain written verification from each employer or other organization of compliance with P.L. 1983, c.142 through 145, and this subchapter.

(b) Each employer or other organization, at the time of offering or renewal of a dental plan contract shall furnish to the health insurer, dental service corporation, or dental plan organization written verification of compliance with P.L. 1983, c.142 through 145 and this subchapter.

(c) Each employer or other organization at the time of offering or renewal of a dental plan contract shall provide in the written notice required by N.J.A.C. 11:10-2.4(b) and (c) an outline of the differences in coverages and cost to the employee or members and their eligible dependents between a dental plan contract and the alternative coverage.

(d) The alternative coverage may be provided through an insurance contract, on a self-funded basis, or by any means which meets the approval of the Commissioner.

(e) Each employer or other organization shall contribute to the alternative coverage an amount equal to the premium or cost which it pays or contributes to the dental plan contract. Such contribution shall be adjusted when the premium or cost which it pays or contributes to the dental plan changes.

11:10-2.6 Separability

If any provision of this subchapter, or its application to any person or circumstances, is held invalid, the remainder of this subchapter and its application to other persons or circumstances shall not be affected.

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New Jersey Statutes

17:48D-9.1 Employer must offer alternative dental coverage

Each employer or other organization which employs or has 25 or more employees or members during the full preceding calendar year and which contributes to a dental plan organization contract which restricts the covered persons in selecting the providers of dental services to a single provider or limited number of providers, shall also offer its employees and their eligible dependents and members and members' eligible dependents at the time a dental benefits plan is offered or renewed the option of selecting alternative coverage which permits covered persons to obtain dental services from any licensed dentist.

17:48D-9.2 Employer contributions

An employer or other organization shall be required to pay for or contribute towards the provision of alternative coverage an amount equal to the premium or cost which it pays or contributes to the dental plan organization contract which limits the number of providers of dental service.

Please keep a copy of this application for your records. If the application is accepted by Aetna it becomes part of the issued Group Agreement and/or Group Policy.