aetna®

Pennsylvania Employer Application

FOR GROUP COVERAGE (50 or fewer employees)

Life, Accidental Death & Personal Loss, Disability, Aetna PPO and Aetna Indemnity plans are underwritten by Aetna Life Insurance Company. Aetna HMO plans, Aetna Health Network plans and Aetna QPOS plans are underwritten by Aetna Health Inc. and Aetna Health Insurance Company. Dental plans are provided or administered by Aetna Life Insurance Company. Vision insurance plans are underwritten by Aetna Life Insurance Company (Aetna). Certain claims administration services are provided by First American Administrators, Inc. and certain network administration services are provided through EyeMed Vision Care ("EyeMed"), LLC.

Company Name (Legal Name)	DBA/Doing Business As (if applicable)		
Street Address (PO Box not acceptable)	City	State	ZIP
Billing Address (if different than above)	City	State	ZIP
Phone Number ( )	Fax Number ( )		
Are there additional addresses/locations for this business? ☐ Yes ☐ No If "Yes," provide all locations and addresses.			
Company Contact – Name and Title	Company Contact E-mail Address		
Billing Contact Name (if different from Company Contact) *Go green – online statements available. Activate access to your eBusiness account at www.aetna.com/employersregister upon receipt of your approval letter.*	Billing Contact E-mail Address		
Enrollment Contact Name (if different from Company Contact)	Enrollment Contact E-mail Address		
SIC Code / Nature of Business		Federal Tax ID Number	Date Business Established (Mo/Yr):
Employer Classification ☐ S Corp ☐ C Corp ☐ Non-Profit ☐ Partnership ☐ Sole Proprietor ☐ LLC ☐ LLP ☐ Other: _____			

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

Requested effective date (may be the 1st or 15th of the month only): _____

Benefit Waiting Period (BWP)

The eligibility date for enrollment will be the first day of the policy month following the waiting period. 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 day of the month, the effective date will be the date of hire.

Do you want to waive the waiting period for present employees enrolling with the group (even those who have not met the full waiting period)? ☐ Yes ☐ No

Benefit Waiting Period for future employees:
First day of policy month following: ☐ 0 Days ☐ 30 Days ☐ 60 Days

Will you provide a dual waiting period? ☐ Yes ☐ No If "Yes," provide the two classes of employees below:
Class 1 Name: _____ Class 1 Waiting Period: _____
Class 2 Name: _____ Class 2 Waiting Period: _____

Medical Coverage Selection

- ☐ PA HMO – Plan Option: _____
- ☐ PA HMO HSA Compatible – Plan Option: _____
- ☐ PA HMO Savings Plus – Plan Option: _____
- ☐ PA QPOS – Plan Option: _____
- ☐ PA Health Network Option – Plan Option: _____
- ☐ PA Health Network Option HSA Compatible – Plan Option: _____
- ☐ PA PPO – Plan Option: _____
- ☐ PA PPO HSA Compatible – Plan Option: _____
- ☐ PA AWH PPO – Plan Option: _____
- ☐ PA AWH PPO HSA Compatible – Plan Option: _____
- ☐ PA Indemnity – Plan Option: _____
- ☐ Other Plan – Plan Option: _____

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.

Dental Coverage Selection (Not available to groups of one)

Contributory Plan:	Plan Option Name _____	Option Number _____
Voluntary Plan:	Plan Option Name _____	Option Number _____

All dental plans are available with an Aetna medical plan. Voluntary Dental is available to groups with 3 or more employees. Orthodontic coverage is available only to groups with 10 or more eligible employees with a minimum of 5 enrolled.

Life and Disability Coverage Selections

- Groups of 2 to 9 eligible employees are limited to one class.
- Groups with 10 to 50 employees may select up to 3 classes of coverage, with a minimum requirement of 3 employees in each class. If more than one class is selected, describe each class of employees, the amount selected for each class, and attach a list of employee names with each class designation. The highest option selected can be no more than 5 times the lowest option.

Groups of 2 to 9	☐ 10,000	☐ 15,000	☐ 20,000	☐ 50,000			
Groups with 10 to 50	☐ 10,000	☐ 15,000	☐ 20,000	☐ 50,000	☐ 75,000	☐ 100,000	☐ 125,000
Life & Disability Packaged Plan (limit one selection)	☐ Low Option	☐ Medium Option	☐ High Option				
Class Description	Class 1	Class 2	Class 3				
Optional Dependent Term Life (Available only to groups with 10 to 50 eligible employees.):	☐ Yes	☐ No					

Vision Coverage Selection (Not available to groups of one)

Aetna Vision Preferred Plan Option Name _____

All vision plans are available in addition to other Aetna coverage selections or standalone.

Vision Coverage Selection (Not available to groups of one)

Aetna Vision Preferred Plan Option Name _____

All vision plans are available in addition to other Aetna coverage selections or standalone.

Business Eligibility

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 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 the information below. • A copy of the Quarterly Wage and Tax Statement must be provided for each group to be included for coverage. • If you file or are eligible to file multiple businesses under one tax ID number, all businesses must be included as one group.		

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

If you have answered "No" to "Is the group to be included" above, please explain why.

Is your company a branch of another company, or does your company have branch offices?			☐ Yes ☐ No
If "Yes,"	- Is each branch office a separate legal entity?		☐ Yes ☐ No
	- Is each branch a location of one legal entity?		☐ Yes ☐ No
	- How many branch offices are there?		
	- Are taxes filed separately or as one common filing?	☐ Separately ☐ One Common Filing	
	- Where is each branch located? (List each branch business address separately.)	Number of Employees at each location	
Are you currently a client company of a Professional Employer Organization (PEO)?			☐ Yes ☐ No
If "Yes,"	- Provide the name of the PEO.		
	- Is group coverage available to you as a client of a PEO?		☐ Yes ☐ No
	- Is the group considered a Co-Employer with the PEO?		☐ Yes ☐ No
	- By enrolling for coverage as a small employer I am not in violation of any contract with the PEO.	☐ Agree ☐ Disagree	

Participation

Number of employees eligible for coverage working a minimum of 25 hours per week			
Number of employees enrolling with Aetna		Number of employees waiving Aetna coverage	
Number of full-time employees excluding union employees		Number of employees working outside Pennsylvania List all states _____	
Number of part-time employees		Number of employees not actively at work	
Number of 1099 employees		Number of COBRA	
Number of union employees		Number in Waiting Period and not eligible	
Are any classes of employees to be excluded? ☐ Yes ☐ No If "Yes," provide excluded class name: _____			
Are Domestic Partners to be included? ☐ Yes ☐ No			

Medicare Primary versus Secondary

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*	☐ Medicare Primary ☐ Aetna Primary
How many full-time and part-time employees have you employed for at least 20 or more weeks during the current or prior calendar year?	

COBRA/TEFRA/DEFRA

Is your employer group required to comply with COBRA regulation?	☐ Yes ☐ No
How many employees have terminated in the last 90 days?	
How many full and part-time employees did you employ 50% of the business days in the prior calendar year? *Include: Full-time, Part-time, Seasonal, Temporary, Union, Owners, Partners, Officers* *Exclude: Self-employed persons, Independent contractors (1099), Directors* Each part-time employee counts as a fraction of an employee, with the fraction equal to the number of hours that the part-time employee worked divided by the hours an employee must work to be considered full-time.	
Are any present or former employees/dependents currently on or eligible to elect COBRA? If "Yes," enter information below. Attach a separate sheet, if necessary.	☐ Yes ☐ No

Name of Applicant	Qualifying Event (e.g., termination of employment, divorce, etc.)	Date of Qualifying Event	Date COBRA Coverage Terminates

Total Average Number of Employees

January 1 through December 31 – What is the average number of employees you employed including any affiliated companies* during the prior calendar year. An employee is any person to whom you issue a W-2. This includes full-time, part-time, and seasonal workers who may or may not have been eligible for your medical plan or covered by Aetna. To calculate average number of employees, determine the average number of employees for each month, add each month's number to get an annual total, and then divide by 12. Round up or down to the nearest whole number.

*If the business is aggregated with one or more other businesses and treated as a single employer under subsection (b) controlled group of corporations, (c) partnerships, proprietorships, etc., under common control, (m) employees of an affiliated service group, or (o) other regulations of section 414 of the Internal Revenue Code, then please provide the combined total number of employees for all businesses that are included in the "single employer group" under the Internal Revenue Code.

Month	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total	Average divided by 12
FT EE														~~~~~~~~
PT EE														~~~~~~~~
Seasonal														~~~~~~~~
Total														

Employer Contribution(s)

Coverage	Medical	Dental	Employee Life	Dependent Life	Life/Disability	Vision
Employer Contribution for Employee	%	%	%	NA	%	%
Employer Contribution for Dependent	%	%	NA	%	NA	%

Overage Dependent Extension

Aetna's standard limiting age for dependents is up to 26. Indicate below if you elect to extend this group health insurance coverage to eligible dependent children up to age 30.

☐ Yes, I elect to extend coverage to eligible dependent children up to age 30. I understand: 1) these dependents must satisfy state-mandated eligibility criteria; 2) these dependents must apply in writing; and 3) the dependent is responsible for the full premium cost of the continued coverage. Please provide employees with Pennsylvania DU30 Supplemental Enrollment Form.

☐ No, I do not elect to extend this group coverage to overage dependents.

Prior Carrier Information

	Replacing Coverage	Carrier Name	Phone Number	Start Date	End Date
Medical Carrier	☐ Yes ☐ No				
Life Carrier	☐ Yes ☐ No				
Disability Carrier	☐ Yes ☐ No				
Dental Carrier	☐ Yes ☐ No				

My current group dental plan has the following, check all that apply:

☐ Discount Dental ☐ Preventive Only ☐ Preventive and Basic ☐ Major Services ☐ Orthodontia - Ortho Max $ _____

Be sure and submit a copy of the most recent benefit summary to verify Major, Ortho and Preventive and Basic coverage.

Has your business ever been insured with Aetna? If "Yes," provide group number: _____ ☐ Yes ☐ No

Is this plan total replacement of any existing group plans? ☐ 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, unless otherwise specifically provided in the plan documents (which consist of the Group Policy and/or Group Agreement). 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.

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

In accordance with current IRS regulations and the 1986 Tax Reform Act, a life insurance 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 schedule. Aetna disclaims any responsibility if the employer elects such a 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.

Participating physicians, hospitals and other health care providers are independent contractors and are neither agents nor employees of Aetna.

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.

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 subjects such person to criminal and civil penalties.

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.

I understand Aetna will rely on the information I provide in determining eligibility for coverage, setting premium rates, compliance with applicable laws, and other purposes, and that any material misrepresentation or fraudulent statement may result in rescission of the group policy, termination of coverage, increase in premiums, or other consequences. Aetna reserves the right to audit and to request documentation as evidence of business activity at any time and from time to time in order to validate my compliance with eligibility and underwriting guidelines as well as validate the applicability of State and Federal laws. I understand that my failure to comply with any such request may also result in termination of coverage, increase in premiums, or other consequences.

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 to the best of my knowledge and belief. I understand that this application will form a part of the Group Agreement or Group Policy issued by Aetna (a sample of which may be available on request), 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 subject to any state requirements.

continued on next page

JOINDER AGREEMENT - REQUEST FOR PARTICIPATION (for Life, Disability, Accidental Death and Personal Loss Coverage): The undersigned employer agrees to the establishment of an insurance trust fund ("Fund") for the purposes of implementing a Trust Agreement ("Agreement"), and to the designation of the Chase Manhattan Bank Delaware, Wilmington, DE, as "Trustee" for the Fund and Agreement. The undersigned, as a Participating Employer in the Industry Trust corresponding to the standard industry classification ("SIC") code selected above: 1) agrees to be bound by the terms of the Agreement and the policy issued to the Trustee (including any amendments); 2) requests coverage for its eligible employees under the policy (subject to applicable underwriting requirements) as of the effective date requested or as of the date of approval of the Employer for participation under the Agreement, whichever is later, and continue as long as the Employer remains actively in business; and 3) agrees to make the required contributions to the Fund; in the event of default, it will be liable to the insurer for such unpaid contributions for the coverage period, and such insurer will terminate coverage. The insurer may also terminate coverage as of the date the group fails to meet minimum underwriting requirements in effect on that date. In addition, the Participating Employer, in accordance with ERISA Title I Section 503, designates Aetna Life Insurance Company ("Aetna") as the Named Fiduciary under the Plan, with complete and discretionary authority to review all denied claims for benefits under the Plan, and to construe disputed/doubtful Plan terms. Aetna shall be deemed to have properly exercised such authority unless it has abused its discretion by acting arbitrarily and capriciously.

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.
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 (SBC) – 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 (https://www.aetna.com/sbcsearch/home) 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 timely delivery. For information on the SBC regulations and distribution requirements, please review the regulations at the HHS website: http://cciio.cms.gov/resources/other/index.html#sbcug

Signed at City, State	Applicant (Company Name)	
Authorized Applicant Signature	Official Title	
Print Name of Authorized Applicant		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, 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 Pennsylvania. 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.

IMPORTANT: Check applicable box if submitting through:
☐ Aetna Marketplace ☐ Private Exchange – Vendor Name: _____
☐ TPA – Vendor Name: _____

Agent/Broker Name:				
SSN:		National Producer Number:		
Agency Name:		Tax ID Number:		
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:				
SSN:		National Producer Number:		
Agency Name:		Tax ID Number:		
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 Agent Name:		TIN:		
Selling Agent Name:		E-mail Address:		
Phone: ( )		Fax: ( )		
Address:		City:	State:	ZIP:
GA Admin Assistant Name:		GA Admin Assistant E-mail Address:		