



Indiana Small Group Business Employer Application

FOR GROUP COVERAGE (2-50 ELIGIBLE EMPLOYEES)

Life, Accidental Death & Dismemberment, Disability and Aetna PPO plans are underwritten by Aetna Life Insurance Company. Aetna HMO plans are underwritten by Aetna Health of Illinois Inc. or Aetna Health Inc. Aetna POS Plans are underwritten by Aetna Health of Illinois Inc., Aetna Health Inc., Corporate Health Insurance Company and/or Aetna Life Insurance Company. Dental plans are provided or administered by Aetna Life Insurance Company.

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 <input type="checkbox"/> Corporation <input type="checkbox"/> Non-Profit <input type="checkbox"/> Partnership <input type="checkbox"/> Sole Proprietor <input type="checkbox"/> Other:		<input type="checkbox"/> SIC Code:	
Nature of Business _____			

Medical Coverage Selection

Groups with 10 to 50 eligible employees may offer any combination of two medical plans that are available in their service area.

Aetna Open Choice - PPO Plan:
 Option 1-05 Option 2-05 Option 3-05
 Option 4-05 Option 5-05 Option 6-05
 Option 7-05 Option 8-05 Option 9-05
 Option 10-05

Aetna Choice (Open Access) - POS Plan:
 Option 1-05 Option 2-05 Option 3-05

Aetna HMO Plan:
 Option 1-05 Option 2-05 Option 3-05
 Option 4-05

Aetna Out-of-State PPO Plan:
 \$250 \$500 \$1,000

Dental Coverage Selection

Aetna Dental™ Plan
 Option 1; DMO
 Option 2; Freedom-of-Choice (DMO/PPO Max)
 Option 3; PPO Max
 Option 4; Freedom-of-Choice (DMO/PPO)
 Option 5; Active PPO
 Option 6; PPO 1500
 Out-of-State PPO Plan (if applicable):
 \$1,000 \$1,500 \$2,000

Orthodontic coverage for dependent children is included in Plan Options 1 & 2, 4-6 and available only to groups with 10 or more eligible employees.

If you have selected an HSA-compatible plan:

- Do you plan on making contributions to your employees' HSA accounts? Yes No
- Do you plan to offer your employees payroll deductions to fund their HSA accounts? Yes No

Life and Disability Coverage Selections

Groups with 10 to 50 eligible employees may select one, two or three options for Life, Accidental Death & Dismemberment, Short Term Disability and Life & Disability Packaged Plan, with a minimum requirement of three employees in each option. 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.) Premium Waiver For Totally Disabled Employees. Yes No
 A waiver of premium for any insured who is totally disabled for a period of at least 6 months shall be made available to the policyholder as a part of the application for any group life insurance policy.

All Groups	Class 1			Class 2			Class 3		
	Life	STD - Plan Option 1	STD - Plan Option 2	Life	STD - Plan Option 1	STD - Plan Option 2	Life	STD - Plan Option 1	STD - Plan Option 2
	<input type="checkbox"/> \$10,000 <input type="checkbox"/> \$15,000 <input type="checkbox"/> \$20,000 <input type="checkbox"/> \$50,000	<input type="checkbox"/> \$100 <input type="checkbox"/> \$200 <input type="checkbox"/> \$300 <input type="checkbox"/> \$400 <input type="checkbox"/> \$500	<input type="checkbox"/> \$100 <input type="checkbox"/> \$200 <input type="checkbox"/> \$300 <input type="checkbox"/> \$400 <input type="checkbox"/> \$500	<input type="checkbox"/> \$10,000 <input type="checkbox"/> \$15,000 <input type="checkbox"/> \$20,000 <input type="checkbox"/> \$50,000	<input type="checkbox"/> \$100 <input type="checkbox"/> \$200 <input type="checkbox"/> \$300 <input type="checkbox"/> \$400 <input type="checkbox"/> \$500	<input type="checkbox"/> \$100 <input type="checkbox"/> \$200 <input type="checkbox"/> \$300 <input type="checkbox"/> \$400 <input type="checkbox"/> \$500	<input type="checkbox"/> \$10,000 <input type="checkbox"/> \$15,000 <input type="checkbox"/> \$20,000 <input type="checkbox"/> \$50,000	<input type="checkbox"/> \$100 <input type="checkbox"/> \$200 <input type="checkbox"/> \$300 <input type="checkbox"/> \$400 <input type="checkbox"/> \$500	<input type="checkbox"/> \$100 <input type="checkbox"/> \$200 <input type="checkbox"/> \$300 <input type="checkbox"/> \$400 <input type="checkbox"/> \$500
Additional options for Groups with 10 - 50 eligible employees	<input type="checkbox"/> \$75,000 <input type="checkbox"/> \$100,000 <input type="checkbox"/> \$125,000	Life & Disability Packaged Plan <input type="checkbox"/> Low <input type="checkbox"/> Medium <input type="checkbox"/> High		<input type="checkbox"/> \$75,000 <input type="checkbox"/> \$100,000 <input type="checkbox"/> \$125,000	Life & Disability Packaged Plan <input type="checkbox"/> Low <input type="checkbox"/> Medium <input type="checkbox"/> High		<input type="checkbox"/> \$75,000 <input type="checkbox"/> \$100,000 <input type="checkbox"/> \$125,000	Life & Disability Packaged Plan <input type="checkbox"/> Low <input type="checkbox"/> Medium <input type="checkbox"/> High	
Class Description									

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

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.

Effective Date

Requested effective date (may be the 1st or 15th of the month only. The actual effective date will be assigned by the Aetna underwriting department if application is approved.)	
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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	_____ %
Short Term Disability	_____ %	N/A
Life & Disability Packaged Plan	_____ %	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	1099	Retired	COBRA or State Continues	Other (i.e., temporary, substitute, seasonal)
Total number of employees						
What is the normal work week you require a full-time employee to work to be eligible for coverage?						_____ hours per week
Total number of employees eligible for coverage (must work a minimum of 30 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.						

COBRA/Tefra/Defra

Is your group subject to COBRA? (20 or more total employees during at least 50% of the working days in the previous calendar year)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is your group (check one) <small>Under Tefra/Defra, Medicare is primary coverage for groups of less than 20 employees and Aetna would be primary coverage for group of 20 or more employees (based on the total number of employees during 50% of the working days during the previous calendar year).</small>	<input type="checkbox"/> Medicare Primary <input type="checkbox"/> Aetna Primary

Business Eligibility

Is the group to be covered part of, or associated/affiliated with, another group or entity, including but not limited to, an association, foundation or multiple employer group?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
If Yes, provide details.			
Has this business filed for Chapter 7, Chapter 11, or Chapter 13 bankruptcy?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
If Yes, provide details.			
List all groups to be covered under this plan?			
Business Name	Tax Identification Number	Owner's Name	Ownership Percentage

Benefit Waiting Period

Waive the waiting period for present employees enrolling with the group.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Waiting period for future employees:	<input type="checkbox"/> 0 days (eligible on the 1 st day of employment) <input type="checkbox"/> 30 days (eligible on the 31 st day) <input type="checkbox"/> 30 days (eligible on the 1 st of month following completion of BWP) <input type="checkbox"/> 60 days (eligible on the 61 st day) <input type="checkbox"/> 60 days (eligible on the 1 st of month following completion of BWP) <input type="checkbox"/> 90 days (eligible on the 91 st day)".

Prior Carrier Information

	Health	Dental	Life	Disability
Is coverage transferring from another carrier	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, provide Carrier Name				
Effective Coverage Date				
Proposed Termination Date				
Total Replacement				
If prior carrier is Aetna, provide Group/Control Number				
Dental Only – Prior coverage included, check all that apply:		<input type="checkbox"/> Major Services <input type="checkbox"/> Orthodontia		

Workers' Compensation Information

Aetna's coverage is not occupational in nature and, consequently, it is not a substitute for Workers' Compensation coverage.

Name of current Workers' Compensation carrier: _____

Effective Date: _____ Termination Date: _____

Is Workers' Compensation coverage provided on all employees? Yes No

If not, please provide a list of all employees enrolling that are NOT covered by Workers' Compensation or similar legislation (including title).

Medical Information

Is any person to be covered unable to work due to illness or injury? Yes No

Is any person unable to perform the normal duties of another person in the same employment class of the same age and sex? Yes No

If yes is answered to either question, attach a sheet with the names of the individual(s), dates and degree of recovery.

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 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.

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 rights and responsibilities of member(s) and will govern in the event of conflicts with any benefits comparison, summary or other description of the plan. Any direct conflict between this form and the plan documents will be resolved according to the terms which are most favorable to the member.

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.

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

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.

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