Aetna®

Michigan Small Group Business Employer Application and Joinder Agreement

FOR GROUP COVERAGE (2 to 50 ELIGIBLE EMPLOYEES)

Life, Accidental Death & Dismemberment, Disability, Aetna PPO plans and Aetna Dental plans are underwritten 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
Bill 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 ☐ LLC ☐ LLP
☐ Other: __________ SIC Code: __________ Nature of Business: __________

Medical Coverage Selection

(Dual Option or Triple Option is available to groups with 5 or more enrolled employees.)

MI PPO:
☐ Plan 1.1 ☐ Plan 2.1 ☐ Plan 3.1 ☐ Plan 4.1 ☐ Plan 5.1
☐ Plan 6.1 ☐ Plan 7.1 ☐ Plan 8.1 ☐ Plan 9.1

MI PPO Split Copay:
☐ Plan 1.1 ☐ Plan 2.1 ☐ Plan 3.1 ☐ Plan 4.1 ☐ Plan 5.1
☐ Plan 6.1

MI PPO HSA Compatible:
☐ Plan 1.1 ☐ Plan 2.1 ☐ Plan 3.1 ☐ Plan 4.1

MI PPO Consumer Directed:
☐ Plan 1.1 ☐ Plan 2.1 ☐ Plan 3.1 ☐ Plan 4.1

MI PPO Basic Hospital: ☐ Plan 1.1

MI Indemnity: ☐ Plan 1.1

☐ **Other Plan:** __________

Out-of-State PPO: ☐ $250 ☐ $500 ☐ $1000

☐ **Out-of-State Traditional 1**

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

Dental Coverage Selection

Aetna Dental™ Plan

Standard

☐ Option 1: DMO®
☐ Option 2: Freedom-of-Choice
☐ Option 3: Freedom of Choice
☐ Out-of-State PPO: ☐ 1000 ☐ 1500
☐ Option 4: PPO Max
☐ Option 5: Active PPO
☐ Option 6: PPO 1500

Voluntary

☐ Option 1: DMO®
☐ Option 2: Freedom-of-Choice
☐ Option 3: PPO Max
☐ Out-of-State PPO: ☐ 1000

Orthodontic coverage is included in Standard Plan Options 1, 2, 3, 5, & 6 and Voluntary Plan Options 1 & 2 for dependent children 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, with a minimum requirement of three employees in each class. 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.)

Life Options for All Group Sizes	☐ $10,000 ☐ $15,000 ☐ $20,000 ☐ $50,000		
Additional Life Options for Groups with 10 - 50 Eligible Employees	☐ $75,000 ☐ $100,000 ☐ $125,000		
Life & Disability Packaged Plan	☐ Low Option ☐ Low Option 2 ☐ Medium Option ☐ Medium Option 2 ☐ High Option		
STD	☐ Option 1 ☐ Option 2 ☐ $100 ☐ $200 ☐ $300 ☐ $400 ☐ $500		
Class Description	**Class 1**	**Class 2**	**Class 3**
Optional Dependent Term Life	(Available only to groups with 10 to 50 eligible employees.) ☐ Yes ☐ No		

Effective Date

Requested effective date may be the 1st or the 15th of the month. The actual effective date will be assigned by the Aetna underwriting department if the Joinder Agreement and Application is approved.	

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.

Business Eligibility

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 any other company(ies) on a combined or consolidated basis?	☐ 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	Ownership Percentage	Number of Employees	Is group to be included
					☐ 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? If Yes - Is each branch office a separate legal entity? ☐ Yes ☐ No - Is each branch a location of one legal entity? ☐ Yes ☐ No	☐ Yes ☐ No
- How many branch offices are there?	
- Are tax filings separately or as one common filing?	☐ Yes ☐ No

- Where is each branch located (list each branch business address separately)?	Number of Employees at each location

Has your business been insured with Aetna within the past 12 months? If Yes, provide group number. ______	☐ Yes ☐ No
Are you currently covered under a PEO (Professional Employer Organization)? If Yes - Provide the name of the PEO. ______ - Is group coverage available to you as a client of a PEO? ☐ Yes ☐ No - Are you considered a Co-Employer with the PEO? ☐ Yes ☐ No - By enrolling for coverage as a small employer you are not in violation of any contractual breach of contract with the PEO? ☐ Yes ☐ No	☐ Yes ☐ No
Do you use the services of a Payroll Company? If Yes, provide the name of the payroll company. ______	☐ Yes ☐ No

Employer Eligibility/Employee Status

Work Location (list by state)	Number of Employees						
	Full-time	Part-time	Retired	COBRA	1099	Union	Other (Temporary, substitute, seasonal, etc.)

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 eligible employees		Total number of employees enrolling		Total number of employees waiving		Total number of employees in waiting period	

Are there excluded classes of employees other than part-time and temporary employees (for example, Union employees)? If Yes, describe class(es) and/or the union local name and number.	☐ Yes ☐ No

Employer Contribution(s)

Coverage	**Medical** (No minimum required)	**Dental** (25% total cost or 50%)	**Employee Life** (2 to 9 – 100% 10 to 50 – 50%)	**Dependent Life** (No minimum required)	**Disability** (2 to 9 – 100% 10 to 50 – 50%)	**Packaged Life & Disability** (2 to 9 – 100% 10 to 50 – 50%)
Employer's Contribution for Employee				NA		
Employer's Contribution for Dependent			NA		NA	NA

Benefit Waiting Period

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

Waive the waiting period for present employees enrolling with the group (even those who have not met the full waiting period).	☐ Yes ☐ No

Waiting period for future employees: ☐ 0 Days ☐ 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 150 Days ☐ 180 Days

COBRA/Tefra/Defra/State Continuation

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
How many employees have terminated in the last 90 days?	
To the best of your knowledge, will any of these employee(s)/dependent(s) exercise their COBRA/State Continuation option?	☐ Yes ☐ No
If Yes, is the employee/dependent presently disabled?	☐ Yes ☐ No
Is your group subject to Tefra/Defra? Under Tefra/Defra, Aetna is primary coverage for groups of 20 or more full-time and part-time employees (based on the total number of employees during 50% of the working days during the previous calendar year). Medicare is primary for groups of less than 20 full-time and part-time employees.	☐ Medicare Primary ☐ Aetna Primary

Prior Carrier Information

	Health	Dental	Life	Disability
Is this group transferring from another group carrier?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If Yes, provide Carrier Name and Telephone Number				
Effective Date of Coverage				
Proposed Termination Date				
Is this total replacement?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If prior carrier is Aetna, provide Group/Control Number				
Dental Only – Prior coverage included, check all that apply:		☐ Major Services ☐ Orthodontia		
Did your plan have a deductible?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Prior Carrier Deductibles:	$______ Individual $______ Family	$______ Individual $______ Family $______ Ortho Maximum		

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 undersigned employer 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 Booklet-Certificate). All statements herein shall be deemed representations and not warranties.

The undersigned employer acknowledges that it has selected this plan based upon written information provided by Aetna and that no 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. Undersigned employer agrees to make payroll and other records directly related to employee's coverage under the plan documents available to Aetna for inspection, at Aetna's expense, at employer's office, during regular business hours, upon reasonable advance request. This provision shall survive termination of the Group Policy.

Undersigned employer has selected, in accordance with applicable state law, the plan to be offered to employer's employees and employer has solely determined any/all health plan options for the employer'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 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. Undersigned employer 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. Aetna Rx Home Delivery, LLC, is a subsidiary of Aetna Inc.

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages.

Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Michigan division of insurance within the department of regulatory agencies.

continued

Signature Section (Continued)

Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Michigan division of insurance within the department of regulatory agencies.

All data that may have a bearing on coverage or premiums will be open for Aetna to inspect while the plan documents are 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 to the best of my knowledge and belief.

I understand that the Application will form a part of the 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 Policy. I understand that Aetna may choose not to accept this Joinder Agreement and Application subject to any state requirements. I understand that 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.

JOINDER AGREEMENT - REQUEST FOR PARTICIPATION (for Life, Disability, Accidental Death and Dismemberment and out-of-state Medical and out-of-state Dental Employee 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.

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

By: ______________________ ______________________
Authorized Applicant Signature — Print Name of Authorized Applicant

______________________ ______________________
Official Title — Date

Questions regarding any of the above information should be directed to your Agent or Aetna Sales Representative.

Agent Certification

I hereby certify that I am not aware of any information not disclosed in this Joinder Agreement and 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 Michigan.
I hereby certify that I have advised the client not to terminate any existing coverage until receiving written notice from Aetna that Aetna has accepted the this Joinder Agreement and Application.

Broker Name:		SSN:		
Agency Name:		TIN:		
Pay Commissions To (Check one.): ☐ Broker ☐ Agency		Phone Number: ( )	Fax Number: ( )	
Address:		City:	State:	Zip:
Signature:	Date:	E-Mail Address:		% of Credit:
Broker Name:		SSN:		
Agency Name:		TIN:		
Pay Commissions To (Check one.): ☐ Broker ☐ Agency		Phone Number: ( )	Fax Number: ( )	
Address:		City:	State:	Zip:
Signature:	Date:	E-Mail Address:		% of Credit:
General Agent Name:		TIN:		
Phone Number: ( )		Fax Number: ( )		
Address:		City:	State:	Zip:
Signature:	Date:	E-Mail Address:		