

Effective Date 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): _____

Group Ownership Information – OPTIONAL

(This information is designed for the purposes of data collection and will not be used for underwriting.)

Check one or both if applicable:

Woman Owned Business Minority Owned Business (indicate status below):
 African American or Black Hispanic or Latino Asian Other _____

Employer Contribution(s)

Coverage	Medical	Dental	Employee Life	Dependent Life	Disability
Employer's Contribution for Employee	%	%	%	NA	%
Employer's Contribution for Dependent	%	%	NA	%	NA

Business Eligibility

Is your company a subsidiary of another company, an affiliate of another company, or under common control with another company?					<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your company file state or federal taxes with another company(ies) on a combined or consolidated basis?					<input type="checkbox"/> Yes <input type="checkbox"/> No
Are there any associated companies to be included that are commonly owned?					<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes to any questions, complete the information below.					
<ul style="list-style-type: none"> • 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?
					<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 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?					<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes - Is each branch office a separate legal entity?					<input type="checkbox"/> Yes <input type="checkbox"/> No
- Is each branch a location of one legal entity?					<input type="checkbox"/> Yes <input type="checkbox"/> No
- How many branch offices are there?					
- Are tax filings separately or as one common filing?					
- 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.					<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you use the services of a Payroll Company? If Yes, provide the name of the payroll company.					<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you currently a client company of a PEO?					<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, - Provide the name of the PEO.					
- Is group coverage available to you as a client of a PEO?					<input type="checkbox"/> Yes <input type="checkbox"/> No
- Is your group currently covered for health insurance under the PEO?					<input type="checkbox"/> Yes <input type="checkbox"/> No
- Who provides the W2 to your employees?					

Benefit Waiting Period

Waive the waiting period for present employees enrolling with the group (even those who have not met the full waiting period).	<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 1 st day of month following completion of BWP)
<input type="checkbox"/> 30 Days (eligible on the 31 st day)	<input type="checkbox"/> 60 Days (eligible on the 1 st day of month following completion of BWP)
<input type="checkbox"/> 60 Days (eligible on the 61 st day)	<input type="checkbox"/> 90 Days (eligible on the 91 st day)

Employer Eligibility/Employee Status

Work Location (list by state)	Number of Employees						Other (Temporary, substitute, seasonal, etc.)
	Full-time	Part-time	Retired	COBRA	1099	Union	
Total number of employees enrolling		Total number of employees waiving			Total number of employees in benefit waiting period		

continued

Employer Eligibility/Employee Status (Continued)

What is the normal work week you require a full-time employee to work to be eligible for coverage?	_____ hours per week
Are there excluded classes of employees other than part-time and temporary employees (for example, Union employees)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, describe class(es) and/or the union local name and number.	

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
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 option?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, is the employee/dependent presently disabled?	<input type="checkbox"/> Yes <input type="checkbox"/> 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.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is your group (check one).	<input type="checkbox"/> Medicare Primary <input type="checkbox"/> Aetna Primary

Prior Carrier Information

	Health	Dental	Life	STD
Is this group transferring from another group 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 Date of Coverage				
Proposed Termination Date				
Is this total replacement?	<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 prior carrier Aetna, provide Group/Control Number				
Did your plan have a deductible?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Prior carrier deductibles:	<input type="checkbox"/> Individual \$ _____ <input type="checkbox"/> Family \$ _____	<input type="checkbox"/> Individual \$ _____ <input type="checkbox"/> Family \$ _____ <input type="checkbox"/> Ortho Max \$ _____		
Dental Only – Prior coverage included, check all that apply:		<input type="checkbox"/> Major Services <input type="checkbox"/> Orthodontia		

Medical Information

Is any person to be covered unable to work due to illness or injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is any person unable to perform the normal duties of an other person in the same employment class of the same age and sex?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes is answered to either question, attach a sheet with the names of the individual(s), dates and degree of recovery.	

Ohio Cancellation Policy

Any group may cancel a signed agreement within seventy-two (72) hours after having signed the agreement to enroll under this plan. Cancellation occurs when written notice of the cancellation is given to the HMO or its agents or other representatives. A notice of cancellation mailed to the HMO shall be considered to have been filed on its postmark date.

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.

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.

continued

Signature Section (Continued)

The plan documents will determine the rights and responsibilities of member(s) and will govern in the event of conflicts with a ny 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 RxHome 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, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

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 understand the 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. 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 (asample 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.

It is unlawful to knowingly provide false, in complete, 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.

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 _____ 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 have advised the client not to terminate any existing coverage until receiving written notice from Aetna of the effective date of the coverage being applied for by this application.

Broker Name: _____ Tax ID or SSN for commissions to be paid: _____
 Agency Name: _____ Phone Number: (____) _____ Fax Number: (____) _____
 Address: _____ City: _____ State: _____ Zip: _____
 Signature: _____ E-Mail Address: _____ % of Credit: _____

Broker Name: _____ Tax ID or SSN for commissions to be paid: _____
 Agency Name: _____ Phone Number: (____) _____ Fax Number: (____) _____
 Address: _____ City: _____ State: _____ Zip: _____
 Signature: _____ E-Mail Address: _____ % of Credit: _____

General Agent Name: _____ Tax ID or SSN for commissions to be paid: _____
 Agency Name: _____ Phone Number: (____) _____ Fax Number: (____) _____
 Address: _____ City: _____ State: _____ Zip: _____
 Signature: _____ E-Mail Address: _____ % of Credit: _____

For Aetna Use Only

Group Number _____ Control Number _____
 SCD _____ Effective Date _____
 Is Agent/Agency licensed and appointed? Yes No Appointment Expiration Date _____