



Pennsylvania Small Group Business Employer Application

FOR GROUP COVERAGE (2 – 50 ELIGIBLE EMPLOYEES)

Life, Accidental Death & Dismemberment, Disability and Aetna Choice Plan PPO are underwritten by Aetna Life Insurance Company. Aetna Primary Care Plan HMO and Aetna Choice Plan POS are underwritten by Aetna Health Inc. Dental plans are provided or administered by Aetna Health Inc. and 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:			SIC Code:

Medical Coverage Selection

Aetna Primary Care™ Plan HMO	<input type="checkbox"/> Value	<input type="checkbox"/> Standard	<input type="checkbox"/> Premier
Aetna Primary Care™ Plan HMO — No Referrals	<input type="checkbox"/> Value	<input type="checkbox"/> Standard	<input type="checkbox"/> Premier
Aetna Choice™ Plan POS	<input type="checkbox"/> Value	<input type="checkbox"/> Standard	<input type="checkbox"/> Premier
Aetna Choice™ Plan POS — No Referrals	<input type="checkbox"/> Value	<input type="checkbox"/> Standard	<input type="checkbox"/> Premier
Aetna Primary Care™ Plan HMO — Deductible and Coinsurance	<input type="checkbox"/> Value	<input type="checkbox"/> Standard	<input type="checkbox"/> Premier
Aetna Out-of-Area Plan PPO (Limited to Out-of-Area Employees)	<input type="checkbox"/> Out-of-Area Plan		

Dental Coverage Selection (Limited to one selection)

Groups with 10 – 50 eligible employees who have selected an Aetna HMO or POS medical plan can select any Dental plan.
 Groups with 26 – 50 eligible employees who have not selected an Aetna medical plan can select either the Standard or Premier Dental plan.

Aetna Dental™ Plans

- Value HMO Rider
- Standard:
 - Freedom of Choice or
 - Dual Choice
- Premier:
 - Freedom of Choice or
 - Dual Choice

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. 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.)

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

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

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): _____

Employer Contribution(s)

	Employer's Contribution for Employee Coverage	Employer's Contribution for Dependent Coverage
	% Contribution	% Contribution
Medical	_____ %	_____ %
Dental	_____ %	_____ %
Basic Employee Term Life (including AD&D)	_____ %	
Optional Dependent Term Life		_____ %
Disability	_____ %	

Groups with 2 to 50 eligible employees: The employer must contribute at least 50% of the employee-only annual premium. Coverage can be denied based on inadequate contributions.

Section 125 Plan

Does the group have a flex plan under Section 125 of the Internal Revenue Service code? Yes No

Employee Eligibility

Work Location (list by state)	Number of Employees				
	Full-time (based on number of minimum hours allowed by state law)	Part-time	Retired	COBRA or State Continuees	Other (i.e., temporary, substitute, seasonal)

Total number of employees: _____
 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: _____
 Are there excluded classes of employees other than part-time and temporary employees (for example, Union employees)? Yes No
 If Yes, describe excluded class(es): _____
 Eligibility date will be the first day of the policy month following the waiting period.
 Waiting period for future employees: 0 days 30 days 60 days 90 days 120 days 180 days

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: _____ Renewal 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.

Prior Carrier Information

Health:

Will coverage be transferring from another carrier: Yes No
 If yes, name of the carrier: _____ Proposed Termination Date: _____
 If prior carrier is Aetna, provide group or control #: _____ Total Replacement: Yes No
 Has the group been uninsured for three or more months prior to the requested effective date: Yes No

Dental:

Will coverage be transferring from another carrier: Yes No
 If yes, name of the carrier: _____ Proposed Termination Date: _____
 If prior carrier is Aetna, provide group or control #: _____ Total Replacement: Yes No
 Prior Coverage included coverage for (check all that apply) Major Services Orthodontia
 Has the group been uninsured for three or more months prior to the requested effective date: Yes No

Life and AD&D:

Will coverage be transferring from another carrier: Yes No
 If yes, name of the carrier: _____ Proposed Termination Date: _____
 If prior carrier is Aetna, provide group or control #: _____ Total Replacement: Yes No

Disability:

Will coverage be transferring from another carrier: Yes No
 If yes, name of the carrier: _____ Proposed Termination Date: _____
 If prior carrier is Aetna, provide group or control #: _____ Total Replacement: 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.

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.

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 at its sole discretion.

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 am licensed and appointed to sell Aetna Small 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.

Agent/Broker Name: _____ Aetna Agent Number/Tax ID/SSN: _____
Agency Name: _____ % of Credit: _____
Phone Number: () _____ Fax Number: () _____
Address: _____ City: _____ State: _____ Zip: _____
Signature _____ Date _____ E-Mail Address: _____

Agent/Broker Name: _____ Aetna Agent Number/Tax ID/SSN: _____
Agency Name: _____ % of Credit: _____
Phone Number: () _____ Fax Number: () _____
Address: _____ City: _____ State: _____ Zip: _____
Signature _____ Date _____ E-Mail Address: _____

General Agent Name: _____ Aetna Agent Number/ID Number: _____
Phone Number: () _____ Fax Number: () _____
Address: _____ City: _____ State: _____ Zip: _____
Signature _____ Date _____ E-Mail Address: _____

Administration Kits

Send Administration Kits to: Group Agent/Broker General Agent

For Aetna Use Only

Group Number _____ Control Number _____ SCD _____
Effective Date _____ MRU _____ Prospect ID _____

