



# Aetna Life Insurance Company

151 Farmington Avenue  
Hartford, CT 06156

# Aetna Health Inc.

1425 Union Meeting Road  
Blue Bell, PA 19422

# New York Small Group Business Employer Application

**FOR GROUP COVERAGE (2-50 ELIGIBLE EMPLOYEES)**

Life, Accidental Death & Dismemberment, and Aetna Managed Choice Plan PPO are provided by Aetna Life Insurance Company. Aetna Primary Care Plan HMO and Aetna QPOS are provided by Aetna Health Inc. and/or Aetna Life Insurance Company. DMO and PPO dental plans are provided by Aetna Life Insurance Company except Dental HMO Rider coverage which is provided by Aetna Health Inc.

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: _____		Nature of Business: _____	

### Medical Coverage Selection

**Managed Choice Open Access:**  
 21a-06  21b-06  22a-06  22b-06  24a-06  
 24b-06  26a-06  26b-06  27-06  29a-06  
 29b-06  32a-06  32b-06

**Managed Choice Open Access (HSA Compatible):**  
 30-06  31-06

**EPO Open Access:**  
 1a-06  1b-06

**Indemnity :**  
 20-06

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 Plans**  
 Option 2: DMO  Option 3: Freedom-of-Choice  
 Option 4: PPO Max  Option 5: Active PPO  
 Option 6: PPO 1500  
 Option 7: Consumer Directed DentalFund  
 Out-of-State:  
 \$1,000  \$1,500

**Voluntary Plans**  
 Option 2: DMO  Out-of-State:  
 Option 3: Freedom-of-Choice  \$1,000  
 Option 4: PPO Max

Orthodontic coverage for dependent children is included in Standard Plan Options 2, 3, 5 & 6 and Voluntary Plan Options 2 & 3 and available only to groups with 10 or more eligible employees.

### Life, Accidental Death & Dismemberment, and Disability Coverage Selection

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 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.)

All Groups	Class 1		Class 2		Class 3	
	Life*	Life & Disability or Packaged Plan	Life*	Life & Disability or Packaged Plan	Life*	Life & Disability or 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 Plans include Dependent Term Life	<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 Plans include Dependent Term Life	<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 Plans include Dependent Term Life
<b>Additional options for Groups with 10 – 50 eligible employees</b>	<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	
<b>Class Description</b>						

\*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** Actual effective date will be assigned by the Aetna underwriting department if application is approved.

Requested effective date (may be the first 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)	_____ %	N/A
Optional Dependent Term Life	N/A	_____ %
Packaged Life & Disability 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	Retired	COBRA or State Continuees	Other (i.e., temporary, substitute, seasonal)

Total number of employees: \_\_\_\_\_

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

Total number of employees eligible for coverage (must work a minimum of 20 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: \_\_\_\_\_

Do you exclude Union employees under this application?  Yes  No

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

**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 (subject to applicable HIPAA requirements for health coverage), unless otherwise specifically provided in the plan documents (which consist of the Group Agreement and/or Group Policy). 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.

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

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 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. 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.

As to Accident and Health Insurance coverage, 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

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. To the best of my knowledge and belief, all information provided in this application is accurate and complete.

I understand that this application will form a part of the Group Agreement or Group Policy issued by Aetna, 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, subject to any state requirements.

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 to sell Aetna Small Group products in the state of New York.

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: \_\_\_\_\_

**For Aetna Use Only**

Group Number \_\_\_\_\_ Control Number \_\_\_\_\_ SCD \_\_\_\_\_ Effective Date \_\_\_\_\_

Is Agent/Agency licensed and appointed?  Yes  No Appointment Expiration Date \_\_\_\_\_