aetna®

AETNA LIFE INSURANCE COMPANY

151 Farmington Avenue
Hartford, CT 06156

New York Small Group Business

Employer Application for Medical, Dental and Vision Coverage

FOR GROUPS OF 1-100 FULL TIME EQUIVALENT EMPLOYEES
Consult Aetna's 2016 Underwriting Brochure for eligibility guidelines

Aetna OAMC plans, Aetna EPO plans, Aetna Indemnity, Aetna Vision℠ Preferred plans and Aetna NYC Community Plan℠ are provided by Aetna Life Insurance Company. DMO® and PPO dental plans are provided by Aetna Life Insurance Company. For Vision coverage, certain claims administration services are provided by First American Administrators, Inc. and certain network administration services are provided through EyeMed Vision Care, LLC ("EyeMed").

Company name (legal name)	Doing business as (if applicable)		
Street address (PO box not acceptable)	City	State	ZIP code
Billing address (if different than above)	City	State	ZIP code
Are there additional addresses or locations for this business? ☐ Yes ☐ No If **yes**, provide all locations and addresses.			
Phone number ( )	Fax number ( )		
Company contact – Name and title	Company contact email		
Billing contact name (if different from company contact) *Online statements are available. Activate access to your eBusiness account at* ***www.aetna.com/employersregister*** *when you get your approval letter.*	Billing contact email		
Enrollment contact name (if different from company contact)	Enrollment contact email		
Nature of business / SIC code	Federal tax ID number	Date business established (Month/Year):	
Employer classification: ☐ S Corp ☐ C Corp ☐ Nonprofit ☐ Partnership ☐ Sole proprietor ☐ LLC filing 1065 ☐ LLC filing 1120 ☐ LLP ☐ Other: _____			

Effective date of group plan The actual effective date will be assigned by the Aetna underwriting department.

Requested effective date (may be the first or fifteenth of the month only): _____

Full-time equivalent employees in the prior calendar year

The "full-time equivalent" (FTE) employee counting method in 26 U.S.C. 4980H(c)(2) must be utilized to determine group size for medical coverage. This method is the same calculation used to determine employer liability under the "Shared Responsibility for Employers" provisions of the ACA and Internal Revenue Code.

A. FTEs from full-time employees. Number of full-time employees working on average 30 hours or more a week (or 120 hours a month) (even if they are not eligible nor enrolling for health coverage) in the prior calendar year.	
B. FTEs from part-time employees, i.e., who worked on average less than 30 hours a week in the prior calendar year. Add up the total number of hours worked in a week by part-time employees and divide by 30. Example: 10 employees working 20 hours a week: 200 ÷ 30 = 6.66 = 7 (rounding to closest number)	
C. Total number of FTEs = A + B in the prior calendar year.	

*A small group must have at least one eligible employee. An "employee" does not include the sole owner of a business or a spouse of the business owner.

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.

Medical coverage selection

- Non-contributory plans-employer pays all: 100% participation, after subtracting valid waivers rounding down
- Contributory plans: 60% participation, after subtracting valid waivers rounding down
- Groups that do not meet the participation requirements are eligible to enroll during open enrollment, November 15 through December 15, for a January 1 effective date.

☐ **Open Access Managed Choice® (OAMC) HSA Compatible** – Plan option: _____
☐ **Open Access Managed Choice® (OAMC) HSA Compatible FH** – Plan option: _____
☐ **Open Access Elect Choice® (OAEPO)** – Plan option: _____
☐ **Open Access Elect Choice® (OAEPO) HSA Compatible** – Plan option: _____
☐ **Savings Plus Open Access Elect Choice® (OAEPO)** – Plan option: _____
☐ **EPO** – Plan option: _____
☐ **Aetna Whole Health (AWH) OAEPO** – Plan option: _____
☐ **NYC Community Plan℠** – Plan option: _____
☐ **Indemnity** (only available if OAMC or PPO networks are not available) – Plan option: _____
☐ **Other** – Plan option: _____

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

Dental coverage selection *(Not available to groups of one.)*

Aetna Dental® Plan *Orthodontic coverage for dependent children is available in some plans for groups with 10 or more eligible employees.*

☐ **Non-voluntary plans**: Option _____ ☐ **Voluntary plans**: Option _____

Vision coverage selection - *(Not available to groups of one. No minimum participation is required.)*

Aetna Vision℠ Preferred – Plan option name _____

All vision plans are available standalone or in addition to other Aetna coverage selections.

Employer premium contribution(s)

Coverage	Medical	Dental
Employer premium contribution for employee	____ % *or* $ _____	____ %
Employer premium contribution for dependent	____ % *or* $ _____	____ %

Employee eligibility

The standard for an employee to be eligible is that the employee must be a "common law employee." Generally, anyone who performs services for an employer is an employee *if the employer can control what will be done and how it will be done.* The common law test to determine control would look at behavioral control, financial control and the type of relationship between the parties. An "employee" does not include the sole owner of a business or a spouse of the business owner.

Temporary employees; consultants; independent contractors; directors and officers who are not an owner, partner or employee; and union members covered by a union sponsored health plan are not eligible unless they meet the definition of "employee" in NY Ins Law Sect. 4235(d) as amended to have the meaning of "employee" set forth in 42 USC 300gg-91(d)(5). Aetna reserves the right to request additional documentation to verify group size or eligibility for participation.

How many hours a week must your employees work to be eligible for coverage?			
Number of employees eligible for coverage (working the minimum hours to be eligible for coverage)			
Number of common law employees			
Number of employees enrolling		Number of employees waiving Aetna coverage	
Number of full-time employees excluding union employees		Number of employees working outside New York List all states: _____	
Number of part-time employees		Number of employees not actively at work	
Number of union employees		Number of COBRA continuees	
Number of employees in waiting period and not eligible			
Classes excluded: ☐ Union – Local # _____			
Are domestic partners to be included? ☐ Yes ☐ No If **yes**, coverage will include same and opposite sex domestic partners. Please notify Aetna in writing if you intend to have coverage apply differently.			
Dependent limiting age: ☐ 26/26 ☐ 30/30 (Dependents must satisfy state-mandated eligibility criteria.)			

Benefit waiting period (BWP)

The eligibility date will be the first day of the policy month following the waiting period, except exactly 90 days following date of hire. Policy month refers to the contract effective date of the first or fifteenth day of the month.

Do you want to waive the waiting period for present employees enrolling with the group (even those who have not met the full waiting period)?	☐ Yes ☐ No

Benefit waiting period for future employees:

First day of policy month following: ☐ 0 days A date of hire effective date is not allowed.
☐ 30 days ☐ 60 days
Or ☐ Exactly 90 days following date of hire

If "0 days" is selected and the employee is hired on the first day of the month, the effective date will be the date of hire.

If "exactly 90 days" is selected, the enrollment eligibility date will begin 90 calendar days following the date of hire.

If the group has a fifteenth of the month bill cycle, the new hire will be effective on the fifteenth of the month following the waiting period chosen, except exactly 90 days following date of hire.

Is a dual waiting period offered? ☐ Yes ☐ No If **yes**, provide the two classes of employees below:

Class 1 waiting period: _____ Class 1 name: _____
Class 2 waiting period: _____ Class 2 name: _____

Business eligibility

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 another company or other companies on a combined or consolidated basis?	☐ Yes ☐ No
Are there any other entities associated with the group that are eligible to file a combined tax return under section 414 of the IRS code? If **yes**, provide legal names of all companies below.	☐ Yes ☐ No
Are there any associated companies to be included with this group that are commonly owned?	☐ Yes ☐ No

If **yes** to any questions, complete the information below. (*If additional space is needed, attach a separate sheet.*)

- 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	Address	Owner's name(s)	Percentage of ownership	Number of employees	Is group to be included?
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No

If you have answered **no** to "Is the group to be included" above, explain why.

Do you use the services of a payroll company? If **yes**, provide the name of the payroll company.		☐ Yes ☐ No
Are you currently a client of a professional employer organization (PEO)?		☐ Yes ☐ No
*If **yes:***	- Provide the name of the PEO. _____	
	- Is group coverage available to you as a client of a PEO?	☐ Yes ☐ No

Total average number of employees – To calculate average number of employees, determine the number of employees for each month, add each month's number to get an annual total, and then divide by 12. Round up or down to the nearest whole number – example: 24.6 = 25. Do not spell out the number – example: write 3, not three. **NOTE:** This information is for rating purposes only and not to determine group size.

What is the average number of employees you employed for the entire previous calendar year regardless of whether or not they were eligible for coverage? An employee is defined as any person for whom the company issues a W-2, including full time, part time, and seasonal workers, and regardless of insurance eligibility. The determination of how to count employees of related corporate entities when calculating group size for medical loss ratio (MLR) purposes is based on whether the entities are considered a single employer under Section 414 of the Internal Revenue Code (subsection (b), (c), (m), or (o)) – and is not based on the multiple tax ID status of the related entities.	

Medicare primary versus secondary

How many full-time and part-time employees have you employed for at least 20 or more weeks during the current or prior calendar year? *Include: Full time, part time, seasonal, temporary, union, owners, partners, officers* *Exclude: Self-employed persons, independent contractors (1099), directors*	
If you employed fewer than 20 employees for 20 weeks in the current or prior year, your group is Medicare Primary. If you employed 20 or more employees for 20 weeks in the current or prior year, your group is Aetna Primary.	

COBRA

How many full and part-time employees did you employ 50 percent of the business days in the prior calendar year? *Include: Full time, part time, seasonal, temporary, union, owners, partners, officers* *Exclude: Self-employed persons, independent contractors (1099), directors* Each part-time employee counts as a fraction of an employee, with the fraction equal to the number of hours that the part-time employee worked divided by the hours an employee must work to be considered full time.	
Is your employer group required to comply with COBRA (fewer than 20 employees)?	☐ Yes ☐ No
How many employees have terminated in the last 90 days?	
Are any present or former employees or dependents currently on or eligible to elect COBRA? If **yes**, enter information below. Attach a separate sheet, if needed.	☐ Yes ☐ No

Name of applicant	Qualifying event (e.g., termination of employment, divorce, etc.)	Date of qualifying event	Date COBRA coverage terminates

Prior carrier information

Is this plan a total replacement of any existing group plans?	Carrier name	Phone number	Start date	End date
Current medical carrier ☐ Yes ☐ No				
Current dental carrier ☐ Yes ☐ No				

My current group dental plan has the following (Check all that apply):

☐ Discount dental ☐ Preventive only ☐ Preventive and basic ☐ Major services ☐ Orthodontia – Ortho max $ _____

Be sure and submit a copy of the most recent dental benefit summary to verify major, ortho, and preventive and basic coverage.

Has your business ever been insured with Aetna? If **yes,** provide group number: _____ ☐ Yes ☐ No

Signature section

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, Group Certificate and/or Group Policy). All statements herein shall be deemed representations and not warranties.

This form is attached to and forms part of the policy and certificate, and may be used to contest the insurance, subject to the incontestability clause.

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, including the Certificate. Applicant agrees to make payroll and other employment records, to validate employment, directly related to employee's plan coverage 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 plan coverage and the applicable plan documents.

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 plan options for the Applicant's employees and the contribution amounts.

The plan documents, including the policy and certificate, 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® and Aetna Specialty Pharmacy®, participating physicians, hospitals and other health care providers are independent contractors and are neither agents nor employees of Aetna. Aetna Rx Home Delivery, LLC, and Aetna Specialty Pharmacy, LLC, are subsidiaries of Aetna Inc.

Applicant agrees to deliver to enrollees all Aetna paper or online member documents and other plan-related materials upon request by Aetna.

Continued on next page

Signature section *(Continued)*

All data that may have a bearing on coverage or premiums will be open for Aetna to inspect while the plan coverage 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, dental or vision 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.

ELECTRONIC ENROLLMENT, BILLING / PAYMENT AND ACCESS AGREEMENT

Enrollment: As part of your participation date, the following terms and conditions apply:

1. You agree to keep copies (paper or electronic) of actual enrollment forms and agree to maintain a reasonably complete record of enrollment and eligibility information (via electronic, interactive voice response technology and/or hard copy format), including evidence of coverage elections, evidence of eligibility, changes to such elections and terminations. Records must be available to Aetna upon request and retained for seven years.
2. For electronic enrollment submissions or changes you agree to create and maintain the records on secure information systems that can generate hard copy records of enrollments or changes entered or maintained on those information systems. Any hard copy records generated pursuant to this provision shall meet reasonable standards of availability, authenticity, non-repudiation and integrity.
3. You represent that all enrollment and eligibility information presented to Aetna is accurate and timely updated. You acknowledge that Aetna can and will rely on such enrollment and eligibility information in determining whether an individual is eligible for benefits under the plan. In the event of a discrepancy between enrollee information (including salary data) submitted and information actually presented by the enrollee on any particular claim for benefits, and the result is that Aetna must pay a higher benefit to reflect the actual information presented by the enrollee, you agree to pay promptly to Aetna applicable back premiums accruing as of the date on which the enrollee's information changed.
4. Insured plans must use Aetna-supplied forms in paper format or electronic format.
5. You are responsible for adhering to both state and federal laws and regulations when submitting terminations to Aetna.
6. If otherwise permitted, when retro-terminations are submitted, we will regard the submission as verification that no premium / contribution was paid by the member / dependent for that period.

Billing / payment: You agree to receive your bill online each month. Any contractual provisions related to non-payment of premium continue to be applicable. I / we understand and agree to the terms set forth in this agreement. By signing below, I represent that I am authorized to sign this agreement.

Access: The undersigned employer agrees that each employee will agree to terms associated with the issuance and use of his/her password and system access. An individual's password may be used only by that individual to access the system and may not be shared for any reason. Each individual is personally responsible for the information entered into the system. If an individual to whom a password has been issued becomes aware of a security breach (an incident in which there occurs attempted or unauthorized access, use, disclosure, modification, or destruction of information or interface with system operations), they agree to contact Aetna.

EMPLOYER ACKNOWLEDGMENT – EMPLOYER WAITING PERIOD

Starting with plan years on or after January 1, 2014, the Affordable Care Act and subsequent federal regulations prohibit group health plans and health insurance issuers from requiring any otherwise eligible plan participants and beneficiaries (employees and dependents) to wait more than ninety (90) days before their health coverage is effective. The regulations define group health plan as the employer or plan administrator. The issuer is defined as the insurance company. Since the requirement applies to both the group health plan and the issuer, each party's obligation is satisfied if the ninety (90) day waiting period is honored. However, if neither party complies, both are subject to penalty.

The Employer Group Policyholder ("Employer") represents that it provides to Aetna, effective date information regarding plan participants and beneficiaries that takes into account the eligibility conditions and waiting period requirements required under federal law, in order for such plan participants and beneficiaries to become eligible for coverage under the Employer's group health insurance coverage with Aetna. In compliance with the waiting period requirements, Aetna shall use the effective date information provided by Employer to enroll such plan participants and beneficiaries in the Employer's group health insurance coverage. In the event this information changes, the Employer shall inform Aetna immediately.

SUMMARY OF BENEFITS AND COVERAGE (SBC) FOR GROUP HEALTH PLAN – PLEASE READ. YOU MUST CHECK BELOW TO CONFIRM:

In accordance with my contract with Aetna to distribute information related to enrollment/coverage information,

☐ I have ☐ I have not

received the Summary of Benefits and Coverage document (**https://www.aetna.com/sbcsearch/home**) associated with the plan information referenced in this application. I confirm I have provided SBCs to plan participants and beneficiaries in compliance with the federal regulation and guidance related to SBCs on this date (MM/DD/YYYY) _____. For information on the SBC regulations and distribution requirements, please review the regulations at the HHS website: **http://cciio.cms.gov/resources/other/index.html#sbcug.**

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.

Signed at city, state	Applicant (company name)	
Authorized applicant signature	Official title	
Print name of authorized applicant		Date

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, for all products being applied for.
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.

IMPORTANT: Check applicable box if submitting through:
☐ Aetna Marketplace ☐ Private exchange – vendor name: _____
☐ TPA – vendor name: _____

Broker name:				
Social Security number:		National producer number:		
Agency name:		Tax ID number:		
Pay commissions to (check one): ☐ Broker ☐ Agency		Phone: ( )	Fax: ( )	
Address:		City:	State:	ZIP:
Signature:	Date:	Email:		% of credit:
Broker admin assistant name:		Broker admin assistant email:		
Broker name:				
Social Security number:		National producer number:		
Agency name:		Tax ID number:		
Pay commissions to (check one): ☐ Broker ☐ Agency		Phone: ( )	Fax: ( )	
Address:		City:	State:	ZIP:
Signature:	Date:	Email:		% of credit:
Broker admin assistant name:		Broker admin assistant email:		
General agent name:		TIN:		
Selling agent name:		Email:		
Phone: ( )		Fax: ( )		
Address:		City:	State:	ZIP:
GA admin assistant name:		GA admin assistant email:		