Connecticut Small Group Business
Employer Application

FOR GROUP COVERAGE (GROUPS OF FEWER THAN 51 ELIGIBLE EMPLOYEES*)

Aetna HMO plans are provided or administered by Aetna Health Inc. Aetna POS plans and In-network portion of the QPOS plans are provided or administered by Aetna Health Inc. and/or Aetna Life Insurance Company. Out-of-network portion of the QPOS plans, Indemnity and PPO plans are provided or administered by Aetna Life Insurance Company. DMO and PPO 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
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 ☐ Corporation ☐ Non-Profit ☐ Partnership ☐ Sole Proprietor ☐ Other: ____________
SIC Code: ____________ Nature of Business: ____________

Medical Coverage Selection

Aetna HMO Open Access:
☐ 1-07 ☐ 2-07 ☐ 3-07

Aetna QPOS Open Access:
☐ 1-07 ☐ 3a-07 ☐ 5b-07 ☐ 7a-07 ☐ 8b-07
☐ 2a-07 ☐ 3b-07 ☐ 6a-07 ☐ 7b-07 ☐ 9-07
☐ 2b-07 ☐ 5a-07 ☐ 6b-07 ☐ 8a-07
☐ A-07 (HSA Compatible)
☐ B-07 (HSA Compatible)
☐ C-07 (HSA Compatible)

Aetna Managed Choice Open Access:
☐ 1-07 ☐ 3-07 ☐ A-07 (HSA Compatible)
☐ 2-07 ☐ 4-07 ☐ B-07 (HSA Compatible)
☐ C-07 (HSA Compatible)

☐ **Aetna Traditional Choice 1-07**

☐ **Mandated CSEHRP HMO**
☐ **Mandated CSEHRP Traditional Choice**
☐ **Other:** ____________

Dental Coverage Selection

Aetna Dental™ Plan

Standard Plans:
☐ Plan Option 1 – Consumer Directed DentalFund
☐ Plan Option 2 – Freedom of Choice
☐ Plan Option 3 – PPO Max ☐ Plan Option 5 – PPO Active
☐ Plan Option 4 – Freedom of Choice ☐ Plan Option 6 – PPO Passive
☐ Out-of-State PPO: ☐ 1000 ☐ 1500

Voluntary Plans:
☐ Plan Option V1 – PPO Max ☐ Plan Option V3 – PPO Active
☐ Plan Option V2 – Freedom of Choice ☐ Out-of-State PPO

Orthodontia coverage is included for dependent children in Standard Plan Options 2, 4, 5 and 6 and Voluntary Plan Options V2 and V3 and is only available to groups with 10 or more eligible employees.

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

Life, Short Term Disability, and Packaged Life/Disability Coverage Selections

Groups with 10 to 50 eligible employees may select one, two or three options for Life, Short Term Disability, and Packaged Life & Disability, with a minimum requirement of 3 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.) Premium Waiver For Totally Disabled Employees. ☐ Yes ☐ No
A waiver of premium for any insured who is totally disabled for a period of at least 6 months shall be made available to the policyholder as a part of the application for any group life insurance policy.

	Class 1			Class 2			Class 3		
All Groups	**Life**	**STD – Plan Option 1**	**or STD – Plan Option 2**	**Life**	**STD – Plan Option 1**	**or STD – Plan Option 2**	**Life**	**STD – Plan Option 1**	**or STD – Plan Option 2**
	☐ $10,000 ☐ $15,000 ☐ $20,000 ☐ $50,000	☐ $100 ☐ $200 ☐ $300 ☐ $400 ☐ $500	☐ $100 ☐ $200 ☐ $300 ☐ $400 ☐ $500	☐ $10,000 ☐ $15,000 ☐ $20,000 ☐ $50,000	☐ $100 ☐ $200 ☐ $300 ☐ $400 ☐ $500	☐ $100 ☐ $200 ☐ $300 ☐ $400 ☐ $500	☐ $10,000 ☐ $15,000 ☐ $20,000 ☐ $50,000	☐ $100 ☐ $200 ☐ $300 ☐ $400 ☐ $500	☐ $100 ☐ $200 ☐ $300 ☐ $400 ☐ $500
Additional options for Groups with 10 – 50 eligible employees	☐ $75,000 ☐ $100,000 ☐ $125,000	**Life & Disability Packaged Plan** ☐ Low ☐ Medium ☐ High		☐ $75,000 ☐ $100,000 ☐ $125,000	**Life & Disability Packaged Plan** ☐ Low ☐ Medium ☐ High		☐ $75,000 ☐ $100,000 ☐ $125,000	**Life & Disability Packaged Plan** ☐ Low ☐ Medium ☐ High	
Class Description									

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.

*Life and Dental Insurance products available only to groups with 2 – 50 eligible employees.

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 % Contribution	Employer's Contribution for Dependent Coverage % Contribution
Medical	________%	________%
Dental	________%	________%
Basic Employee Term Life (including AD&D)	________%	N/A
Optional Dependent Term Life	N/A	________%
Short Term Disability	________%	N/A
Packaged Life & Disability	________%	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 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: ______________________

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

Short Term 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

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 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.

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 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.

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.

JOINDER AGREEMENT - REQUEST FOR PARTICIPATION (For life, disability, accidental death and dismemberment, out-of-state medical and out-of-state dental employee benefits): 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.

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 Connecticut.

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 ____________________